EASTON FAMILY CHIROPRACTIC

PLEASE PRINT CLEARLY AND FILL IN BOTH SIDES COMPLETELY

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Email:_____ □ Male □ Female

Health History: I'm here for: □ Wellness Care □ A Health Concern □ Auto Accident

Problem area(s):_____ Work Related? □ Yes □ No

Date of onset: _____ □ Sudden □ Gradual Duration: □ Hours □ Days □ Months □Years

Pattern of problem: □ Constant □ Intermittent □ Occasional □ _____

Initiating Factors: _____

What makes it better? _____

What makes it worse? _____

List any current medications: _____

_____

List any past surgeries & dates: _____

_____

List any past accidents & dates: _____

_____

Personal & Family History: Marital Status: _____

Spouse's name and health status: _____

Children's names, ages, and health status: _____

_____

Occupation: _____ Employer: _____

Chiropractic History:

Have you ever been to a chiropractor before? □ Yes □ No If Yes: Doctor's Name:_____

Date of last chiropractic visit: _____ Reason for care: _____

Date of last chiropractic x-rays: _____ How long were you under care? _____

Where did you hear about our office? _____

Please check any that apply:

Condition, Symptom or problem	Constant or Frequent	Occasional or Sometimes
Grating/Grinding Neck	□	□
Neck Pain	□	□
Shoulder Pain	□	□
Arm/Hand Pain	□	□
Mid Back Pain	□	□
Low Back Pain	□	□
Hip Pain	□	□
Leg/Foot Pain	□	□
Disc Problems	□	□
Arthritis	□	□
Other Joint Pain	□	□
Numbness	□	□
Cold Hands/Feet	□	□
Pins and Needles	□	□
Headaches	□	□
Migraines	□	□
Dizziness	□	□
Ringing in the Ears	□	□
Earaches	□	□
Hearing Loss	□	□
Sinus Trouble	□	□
Frequent Colds	□	□
Difficulty Breathing	□	□
Allergies	□	□
Asthma	□	□
Chronic Cough	□	□
Chest Pains	□	□
Heart Problems	□	□
High Blood Pressure	□	□
Low Blood Pressure	□	□
Digestive Problems	□	□
Urinary Problems	□	□
ADD/ADHD	□	□
Diabetes	□	□
Cancer	□	□
Loss of Sleep	□	□
Faulty Posture	□	□
Painful Menstrual Cycles	□	□
Irregular Menstrual Cycles	□	□
Pregnant at this time?	□Yes	□No

Other:_____

_____

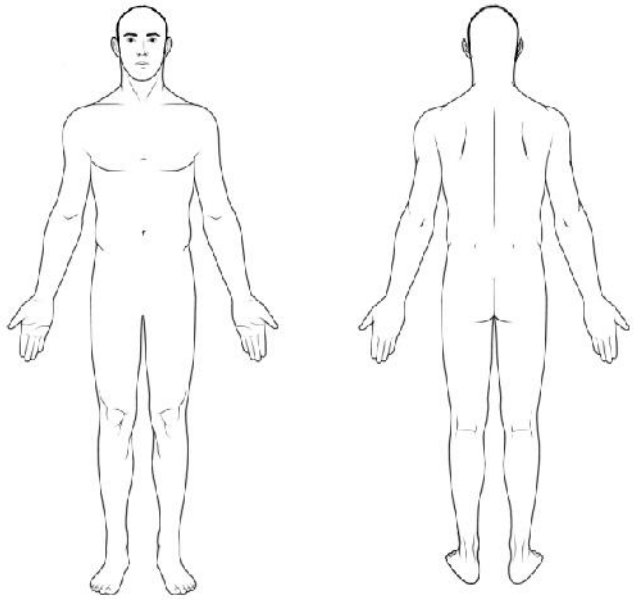
_____

I certify that this information is accurate and correct to the best of my knowledge.

_____

Signature Date

Circle the areas where you have any problems, pain or discomfort.



Please fill in any other health information you feel we might need for your care.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby notify all concerned, that I neither suspect nor know positively at this time that I may be pregnant. I release this clinic and its doctors from any and all damages arising from any and all procedures, of a diagnostic or treatment nature with reference to the possibility of pregnancy.

_____

Signature Date