ALTERNATIVE HEALTH CARE CHIROPRACTIC

CONFIDENTIAL

Today's Date _____/_____/_____

Name _____

Parent's Name (If patient is a minor) _____

Birth Date _____/_____/_____ Sex M F

Address _____

City, State, ZIP _____

Phone _____

Email Address: _____

☐ Yes, sign me up for the AHC newsletter

Welcome
to our practice!
We look forward to meeting you.

Marital Status: S M D W Spouse's name: _____

Occupation _____ Employer _____

Employer's City, State, ZIP _____

Who may we thank for referring you? _____

Present complaint

What brings you to our office today? _____

When did it begin? _____ How did it happen? _____

What activities aggravate the condition? _____

What gives relief? _____

Does the pain radiate? ☐ Yes ☐ No If so, where does it radiate? _____

Please circle the number that best describes the pain. *No pain* 0 1 2 3 4 5 6 7 8 9 10 *Severe*

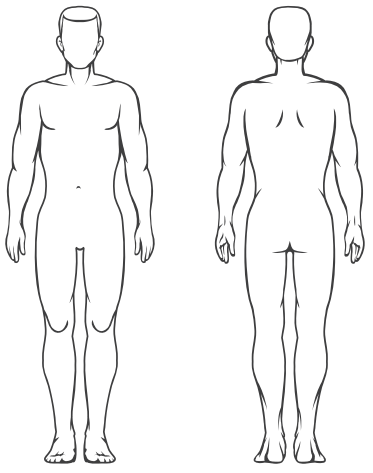
What time of day is it present? ☐ Constant ☐ Comes and goes ☐ Morning ☐ Afternoon ☐ Night ☐ Randomly

Is it getting better, worse, or staying the same? ☐ Better ☐ Worse ☐ Same

Is it interfering with your ☐ Work ☐ Sleep ☐ Exercise ☐ Daily Routine ☐ Other _____

Other doctors seen for this condition _____

Have you ever been under chiropractic care? ☐ Yes ☐ No Doctor's name _____



Left

Right

Draw in your pain

☐ Dull/achy

☐ Burning

☐ Numb/tingling

☐ Sharp/stabbing

☐ Shooting

☐ Tight ☐ Other _____

Name _____ CONFIDENTIAL

Medical History

Have you been treated for any health condition by a M.D. in the last year? ☐ Yes ☐ No

If yes, what were you treated for? _____

Name of primary medical provider: _____

What prescription meds are you taking? _____

Are you wearing: ☐ Heel Lifts ☐ Arch Supports

Have you had x-rays/MRI/CT imaging in the past? ☐ Yes ☐ No Why? _____

Check all of the following conditions that apply to you.

☐ High Blood Pressure	☐ Osteoporosis	☐ TMJ/Jaw Issues	☐ Heart Issues
☐ Rheumatoid Arthritis	☐ Digestive Issues	☐ Stroke/TIA	☐ Osteoarthritis
☐ Frequent Constipation	☐ Hepatitis	☐ Concussion	☐ Plantar Fasciitis/Foot Pain
☐ Polio	☐ Nervousness/Anxiety	☐ Cancer	☐ Carpel Tunnel Syndrome
☐ Frequent Headaches	☐ Numbness/Tingling	☐ Diabetes	☐ Migraines
☐ Allergies	☐ Multiple Sclerosis	☐ Dizziness/Vertigo	☐ Heartburn/Reflux
☐ Seizures	☐ Asthma	☐ Other_____	

Describe any operations you've had and when (approx.) _____

_____

_____

Are you pregnant? ☐ Yes ☐ No # Pregnancies _____ # Children _____ Any complications? ☐ Yes ☐ No

Patient's Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Office Use Only

Seated BP (mmHG) / Pulse (bpm):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctor Signature_____ Date_____