GUARDIAN
CHIROPRACTIC

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name_____ Date_____/_____/_____ S/S_____-_____-_____
First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date_____/_____/_____ Height_____ Weight_____ e-mail address: _____

Who may we thank for referring you to us? _____

SO WE CAN GET TO KNOW YOU BETTER

Your Employer_____ Occupation_____

Business Address_____ City_____ State_____ Zip_____

Spouse/ Parent's Name_____ Phone_____

Are you married? ❒Yes ❒No Do you have children? ❒Yes ❒ No

Name(s) & Age_____

Person to contact in case of an emergency_____ Phone_____

HEALTH HISTORY

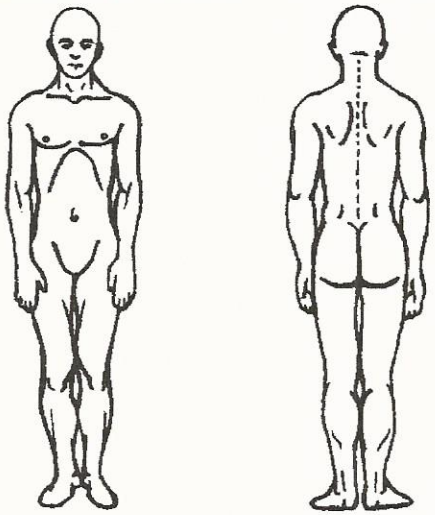
Do you currently have or have you previously had any of the following symptoms:

- ❒ Headaches
- ❒ Neck Pain
- ❒ Neck Stiffness
- ❒ Mid Back Pain
- ❒ Low Back Pain
- ❒ Arm Pain
- ❒ Leg Pain
- ❒ Pins and Needles in Arms
- ❒ Pins and Needles in Legs
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Cold Hands
- ❒ Cold Feet
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Mood Swings
- ❒ Sleeping Problems
- ❒ Fatigue
- ❒ Depression
- ❒ Chest Pain
- ❒ Shortness of Breath
- ❒ Cold Sweats
- ❒ Fever
- ❒ Fainting
- ❒ Dizziness
- ❒ Loss of Balance
- ❒ Light Sensitivity with Eyes
- ❒ Ringing/ Buzzing in Ears
- ❒ Loss of Memory
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Upset Stomach
- ❒ Constipation
- ❒ Diarrhea
- ❒ Urinary Problems
- ❒ Heartburn
- ❒ Ulcers
- ❒ Allergies
- ❒ Menstrual Pain
- ❒ Menstrual Irregularity

Do you smoke? ❒Yes ❒No If yes, how much?_____

Do you drink alcohol? ❒Yes ❒No If yes, how much?_____

PLEASE MARK YOUR CURRENT AREAS OF COMPLAINT:



Rate your pain: None 1 2 3 4 5 6 7 8 9 10 Intense

How often do you notice your symptoms? ❒ Constantly ❒ Frequently ❒ Occasionally

Does anything relieve your pain? _____

What aggravates your pain? _____

Please describe any activities that are restricted due to this injury?

_____

When did you first notice these symptoms? _____

Have you had this problem before? ❒ No ❒ Yes, When? _____

Have you been adjusted by a Chiropractic before? ❒ Yes ❒ No If yes, who? _____

Have you had x-rays before? ❒ No ❒ Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: ❒ None

_____

Surgical History: _____

Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

Which best describes your health goals: ❒pain relief only ❒correct entire problem ❒ wellness/ preventative care

Again, thank you for choosing us for your health care needs!

DATE: _____/_____/_____ **SIGNATURE:** _____

PARENT/ GUARDIAN: _____