ABOUT YOU …

Name:_____ Age:_____ D.O.B:_____Sex:_____

Home Address:_____ City/State:_____ Zip:_____

Home Phone:_____Cell Phone_____ Marital Status _____ Spouse:_____

Email Address: _____

Preferred Language:_____ Race:_____ Are you Hispanic or Latino:_____

Employer: _____ Occupation:_____

Work Phone:_____ Who told you about Healing Hands?_____

Name and No. of Emergency Contact:_____

Have you ever received chiropractic care? **Y N** With whom?_____

Do you have a family medical doctor? **Y N** Who?_____Last medical exam _____

WOMEN: Are you pregnant? **Y N** Date of last monthly period: _____

CURRENT HEALTH CONDITION

Current health complaints/reason for consulting our office:

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?_____

In addition to the main reason for your visit today, what additional health goals do you have? _____

Were other doctors seen for this condition? **Y N** Who?_____ Results:_____

Has this condition occurred before? **Y N** Are the injuries a result of an accident? **Y N**

If yes, how did it occur?_____

Please list any medications/supplements currently taking (include dosage/frequency): _____

Please list any allergies AND reactions to medications:_____

Please describe your daily activities for work, home, or school such as sitting, standing, lifting, phone use:

PAST HEALTH HISTORY

Have you had an accident, even as a passenger, in a(n): **(give dates)**

Automobile:_____Motorcycle:_____Bicycle:_____Other:_____

Medical interventions: **(circle all that apply)**

Hospitalizations PT Surgery Heart Appendix Hysterectomy Spinal Eye Organ removal Other

Explain with dates:_____

Injuries: Have you ever had…**(circle all that apply)**

Broken Bones Spinal/Nerve Disorder Used a crutch/walker Used Neck/Back Bracing Been Unconscious Sports Injuries

Explain with dates:_____

Do you consume: AlcoholCoffee/caffeine Water Intake If so how much:_____

Please Circle your smoking status: Everyday Some Days Former Never

Exercise: None Moderate Daily

Have you ever had/have any of the following diseases? (circle all that apply)

Heart Diabetes Cancer Thyroid Issues Lymes Tuberculosis Hepatitis Chicken Pox STD AIDS MS

Circle any of the following conditions you have had in the past six months:

Musculo-skeletal
Arthritis/RA/Gout
Low Back Pain
Neck/Arm Pain
Shoulder Pain
Joint Pain/Stiffness
Knee Pain
Walking Difficulties
Difficulty Chewing/TMJ
General Stiffness

Nervous System
Anxiety
Headaches/Migraines
Numbness/Tingling
Paralysis
Dizziness/Fainting
Forgetfulness
Confusion/Depression
Fibromyalgia
Convulsions

Sensory
Cataracts/Glaucoma
Sore Throat/Frequent Colds
Earaches/Hearing Trouble
Stuffy Nose/Congestion
Ringing In Ears

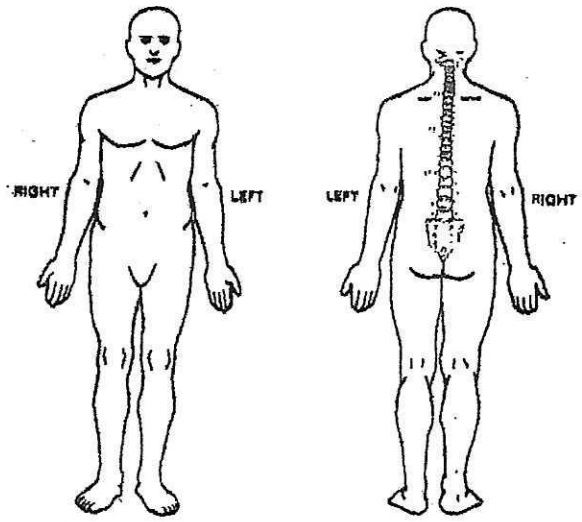
Male/Female
Menstrual Irregularity/Cramps
PMS
Vaginal Pain/Infections
Breast Pain/Lumps
Prostate Issues/ED
Sexual Dysfunction

Digestive
Heartburn/Acid Reflux
Diarrhea/Constipation
Ulcer
Frequent Nausea/Vomiting
Poor/Excessive Appetite
Excessive Thirst
Hemorrhoids
Liver/Gall Bladder Issues
Sudden Weight Change
Food Sensitivities
IBS/GERD/Colitis

Cardiovascular/Respiratory
Shortness of Breath
High Blood Pressure
High Cholesterol
Heart Problems
Irregular Heartbeat/ Pacemaker
Chest Pains
Varicose Veins/Poor Circulation
Ankle Swelling
Emphysema/Pneumonia

Urinary
Frequent Urination/Leakage
UTI
Kidney Stones

Please outline the area(s) of your discomfort…



Quality of Symptoms Please circle what it feels like

Numbness	Burning
Tingling	Shooting
Stiffness	Throbbing
Aching	Sharp

Signature_____ Date_____