AME:
AME:

DATE: _____

Are your present problems due to an injury? PYes N Enter the date of the injury: Was the injury? Auto Accident Personal Injury Other:							
Has the accident been reported? DYes DNo If so, to whom? DTo Employer Auto Carrier Dther:	Are your present problems due to a	n injury? 🛛 Yes 🗅 N	N Enter the date of	the injury	/:		
List symptoms experienced immediately after the injury:	Was the injury? D Auto Accident	Personal Injury	Other:				
Do you have any current work restrictions due to this condition? Yes No List symptoms you are experiencing today: Choose the severity level associated with each symptom [1] Very Mild [2] [3] [4] [5] [6] [7] [8] [9] [10] Seve HABITS FAMILY HISTORY EVENTUAL STORY EVENTUAL STORY FORMER STORE Current Some Day Smoker Diabetes Cancer Back Pain Former Smoker Current Some Day Smoker Diabetes Cancer Back Pain Former Smoker Current Some Day Smoker Diabetes Cancer Back Pain Former Smoker Current Some Day Smoker Mother Concernent Store Back Pain Former Smoker Current Some Day Smoker Mother Concernent Store Back Pain Former Smoker Current Some Day Smoker Mother Concernent Store Back Pain Former Smoker Current Some Day Smoker Mother Concernent Store Back Pain Former Smoker Concernent Store Back Pain Former Smoker Current Some Day Smoker Mother Concernent Store Back Pain Former Smoker Current Some Day Smoker Back Pain Forquency: Oral Intravenous Forequency: Began Use: Began Use	Has the accident been reported?	Yes DNo If so, to	o whom? 🛛 To Emp	oloyer 🗖	Auto Ca	rrier Other:	
List symptoms you are experiencing today:	List symptoms experienced immedi	iately after the injury	y:				
Choose the severity level associated with each symptom (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Sevent for the symptom HABITS FAMILY HISTORY □ Every Day Smoker □ Current Some Day Smoker □ Diabetes Cancer Back Pain □ Former Smoker □ Never Smoker Mother □ □ □ Drinking Alcohol □ Coffee/Caffeine Father □ □ □ Water Daily □ Exercise Are you taking any medication (prescription or over-the-counter)? □ Dyes □ No If Yes, please indicate the following: Medication:	Do you have any current work restr	rictions due to this c	ondition? \Box Yes \Box N	0			
Choose the severity level associated with each symptom (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Sevent for the symptom HABITS FAMILY HISTORY □ Every Day Smoker □ Current Some Day Smoker □ Diabetes Cancer Back Pain □ Former Smoker □ Never Smoker Mother □ □ □ Drinking Alcohol □ Coffee/Caffeine Father □ □ □ Water Daily □ Exercise Are you taking any medication (prescription or over-the-counter)? □ Dyes □ No If Yes, please indicate the following: Medication:	List symptoms you are experiencin	o todav					
HABITS FAMILY HISTORY □ Every Day Smoker □ Current Some Day Smoker □ Diabetes Cancer Back Pain □ Former Smoker □ Never Smoker Mother □ □ Drinking Alcohol □ Coffee/Caffeine Father □ □ Drinking Alcohol □ Coffee/Caffeine Father □ □ Water Daily □ Exercise Are you taking any medication (prescription or over-the-counter)? □ Yes □ Yes Medication:							
□ Every Day Smoker □ Current Some Day Smoker Diabetes Cancer Back Pain □ Former Smoker □ Never Smoker Mother □ □ Drinking Alcohol □ Coffee/Caffeine Father □ □ □ Drinking Alcohol □ Coffee/Caffeine Father □ □ □ Water Daily □ Exercise □ □ □ Are you taking any medication (prescription or over-the-counter)? □ Yes □ No If Yes, please indicate the following:	-	x wan cach sympton					
Former Smoker Never Smoker Mother Image: Contract of the state of the st		ne Dav Smoker					
Water Daily Exercise Are you taking any medication (prescription or over-the-counter)? If Yes INO If Yes, please indicate the following:		-	Mother				
Are you taking any medication (prescription or over-the-counter)? If Yes. INO If Yes, please indicate the following:	Drinking Alcohol Coffee/Caffe	ine	Father				
If Yes, please indicate the following:	□Water Daily □Exercise						
If Yes, please indicate the following:	Are you taking any medication (pr	escription or over-t	he-counter)? D Yes	DNo			
Route: Oral Intravenous Route: Oral Intravenous Frequency:	If Yes, please indicate the followin	g:					
Frequency:							
Began Use:							
Medication: Medication: Route: Oral Intravenous Frequency:	Frequency:		Frequ	ency:			
Route: Oral Intravenous Route: Oral Intravenous Frequency:	Medication		Began Use:				
Began Use:							
Began Use:	Frequency:		Frequ	iency:			
Allergy:			Begar	n Use:			
Have you ever had any surgeries? Dyes DNo (If yes, please enter the approximate date of surgery.) DATE DATE DATE Back Operation Hernia Gall Bl Female Organs Thyroid Stomac Other Thyroid Stomac PRIOR CHIRO CARE: YESNO LAST ADJUSTMENT: TREATED BY: CHIROPRACTOR YES NO PRIOR CHIROPRACTOR:	Do you have allergies to medicatio	<u>n?</u> D Yes D No If	Yes, please indicate	the follo	wing:		
DATE DATE DATE Back Operation Hernia Gall Bl Female Organs Thyroid Stomac Other Stomac Other Stomac PRIOR CHIRO CARE: YES NO LAST ADJUSTMENT:	Allergy: Reaction	on:	Allergy:		React	ion:	
DATE DATE DATE Back Operation Hernia Gall Bl Female Organs Thyroid Stomac Other Stomac Other Stomac PRIOR CHIRO CARE: YES NO LAST ADJUSTMENT:	Have you ever had any surgeries?	DYes DNo (If ve	s, please enter the	approxin	nate date	e of surgerv.)	
Female OrgansThyroidStomac Other CHIROPRACTIC/MEDICAL HISTORY & DATA PRIOR CHIRO CARE: YESNO LAST ADJUSTMENT: TREATED BY: CHIROPRACTOR YESNO PRIOR CHIROPRACTOR:							
Other	Back Operatio	m	Hernia				Gall Bladde
<u>CHIROPRACTIC/MEDICAL HISTORY & DATA</u> PRIOR CHIRO CARE: YES NO LAST ADJUSTMENT: TREATED BY: CHIROPRACTOR YES NO PRIOR CHIROPRACTOR:	Female Organ	s	Thyroid				Stomach
PRIOR CHIRO CARE: YESNOLAST ADJUSTMENT: TREATED BY: CHIROPRACTOR YESNO PRIOR CHIROPRACTOR:	Other						
TREATED BY: CHIROPRACTOR YES NO PRIOR CHIROPRACTOR:	CHIROPRACTIC/MEDICAL HIS	TORY & DATA					
	PRIOR CHIRO CARE: YES N	JO LAST ADJ	USTMENT:				
	TREATED BY: CHIROPRACTOF	R YES NO P	RIOR CHIROPRA	CTOR:			

OPERATIONS AND PROCEDURES

OI ERATIONS AND I ROCEDCRES					
GENERAL SYMPTOMS	GASTRO-INTESTINAL	NOSE/EAR/THROAT	RESPIRATORY		
Allergy(What)	Belching or Gas	□ Asthma	Chest Pain		
	Colon Trouble	Deafness	Chronic Cough		
Bronchitis	Constipation	Earache	Difficulty Breathing		
Chills	Diarrhea	Ear Discharge	□ Spitting Blood		
Convulsions	Gall Bladder Trouble	Ear Noises	Spitting Phlegm		
Dizziness	Hemorrhoids	Thyroid Problems	GENITO-URINARY		
□ Fatigue	Liver Trouble	□ Hay Fever	Bed Wetting		
Headache	□ Nausea	□ Nasal Obstruction	Blood in Urine		
Loss of Sleep	Stomach Pain	□ Nose Bleeds	Frequent or painful Urination		
Loss of Weight	□ Vomiting	Pain in Eyes	☐ Inability to Control Urine		
□ Night Sweats	□ Bloody Stools	Blurred Vision	□ Kidney Infection		
□ Numbness or Pain (arms,hands,Legs)	Acid Reflux	□ Sinusitis	☐ Kidney Stones		
	□ Irritable Bowel	□ Sore Throats	□ Prostate Trouble		
MUSCLES & JOINTS	CARDIO-VASCULAR	SKIN OR ALLERGIES	FOR FEMALES ONLY		
🗆 Hernia	High Blood Pressure	Bruising Easily	Cramps		
□ Pain Between shoulders	Low Blood Pressure	Dryness	□ Hot Flashes		
Painful Tail Bone	Chest Pain	Eczema	Irregular Cycle		
□ Stiff Neck	Heart Trouble	□ Itching	□ Painful Periods		
□ Spinal Curvature	Poor Circulation	Sensitive Skin			
□ Back Pain	□ Rapid/Slow Heart	□ Skin Eruptions			

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

Appendicitis	Anemia	Heart Disease	Arthritis	Measles	□Epilepsy
Rheumatic FeverTuberculosis	MumpsDiabetes	Mental DisorderCancer	□Polio □Venereal Disease		Pleurisy

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

**Patient's/Guardian's Signature: ____

Date:	
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