Patient Name:_____**Date:**_____/_____/_____

Age:_____ **Male** ☐ **Female** ☐ **D.O.B:**____/___/_____.

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Address:_____

STREET CITY ZIP

Tel: (H)_____(W)_____(Cell)_____

Spouses name:_____**Number of children:**_____

Your Employer:_____**Occupation:**_____

Employers Address:_____

E-mail Address:_____

Primary Care Physician:_____**Tel:**_____

Most recent visit:_____/_____/_____

Health History:

Give a reason for seeking chiropractic care:_____

_____

Describe any health problems and how long you have had them:_____

_____

Are you currently taking any medication: yes no **If yes, what medication and for what condition:**_____

Mark physical &/or administrative duties that cause pain: ☐ **lifting** ☐ **bending** ☐ **twisting** ☐ **Prolonged postures** ☐ **normal sleeping postures**

Have you stopped working since the injury: yes no **If no, are you working in distress:** yes no **If yes, is it because of finances:** yes no

What have you been unable to do since the onset of pain: ☐ **Exercise** ☐ **Play sports** ☐ **Household chores** ☐ **Take care of children** ☐ **Play with children**

What other activities have you been unable to do because of the pain:_____

_____

Do you smoke cigarettes: yes no **if yes, how many:**_____ **Do you drink alcohol:** yes no **if yes, how often and how much:**_____

Past medical history: Any other motor vehicle/work accidents: yes no

If yes, what were the dates and what were the injuries:_____

_____

Have you had any previous injuries (sports – home chores) to your neck, middle or lower back or any extremities: yes no **If yes, please describe injury; its date; and where it occurred:**_____

_____

Have you ever been treated for a medical condition: yes no **If yes, when and for what condition and did it involve surgery:**_____

_____

_____

For Women: Are you taking birth control: yes no **Are you pregnant:** yes no

If yes, how long:_____**Nursing:** yes no

Have you ever been treated by a Chiropractic Doctor: no yes **If yes, for what:**

_____

Did this injury require a hospital visit: ☐ Ambulance ☐ Private transportation

Name and location of the Hospital:_____

What was done at Hospital: X-rays (of what):_____

Medication: (what)_____

Anything else:_____

Have you seen any other doctors / nurses since accident and what was done:_____

_____

_____

Has your condition been getting: ☐ worse ☐ staying the same ☐ better

Indicate the areas of pain/stiffness that still exist as a result of this accident:

☐ neck ☐ shoulders ☐ middle back ☐ lower back ☐ hand ☐ wrist ☐ elbow

☐ arm ☐ hip ☐ buttock ☐ thigh ☐ knee ☐ leg ☐ ankle ☐ chest ☐ jaw

Indicate other symptoms as a result of this injury:

☐ headaches ☐ dizziness ☐ ringing in ears ☐ memory loss ☐ blurred vision

☐ nausea ☐ tension ☐ fatigue ☐ numbness/tingling (where)_____

_____

Other symptoms or comments:

_____

_____

Surgical History: ☐ Yes ☐ No ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Shoulder ☐ Knee Rt Lt

Other:_____

Illness: ☐ Diabetes ☐ Hypertension ☐ Myocardial Infarction ☐ COPD ☐ Stroke ☐ Cancer

☐ MS ☐ Other:_____

Family Medical History: ☐ Diabetes ☐ Hypertension ☐ Myocardial Infarction ☐ COPD

☐ Stroke ☐ Cancer ☐ MS ☐ Other:_____

Wellness Commitment

At Highland Chiropractic we are dedicated toward achieving the goal of total lasting health for our members and their families. To better help you achieve this; we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10%-----20%-----30%-----40%-----50%------60%-----70%-----80%-----90%------100%

We are pleased you have chosen our office for your chiropractic care and we are sure you will be telling people of your success. We would like to thank the patient/friend who referred you to our office.

Referred By:_____ OR How did you here about us?_____

PATIENT'S SIGNATURE:_____