LAST NAME ____________________ FIRST NAME ____________ MIDDLE ____________

ADDRESS ____________________ ____________ BIRTHDATE ________ AGE ______

CITY ____________ STATE ________ ZIP ________ ____________________

OCCUPATION ____________________ SPOUSE ____________________

EMPLOYER ____________________ SPOUSE'S OCCUPATION ____________________

OF CHILDREN ______ PHONE ____________ WORK ____________ EMPLOYER ____________________

Contact in case of emergency ____________________ REFERRED BY ____________________

What is your major complaint? ____________________

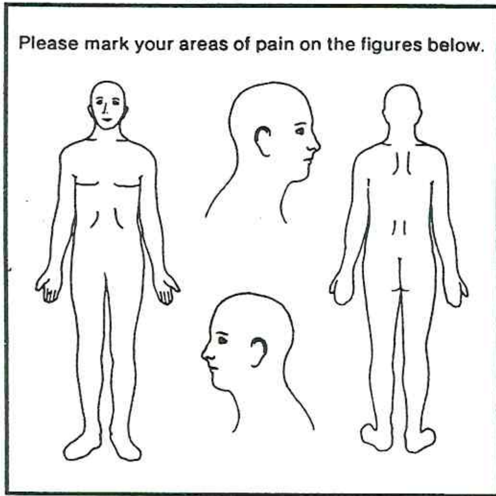
Other complaints? ____________________

How long have you had this condition? ____________ Have you had this or a similar condition in the past? ____________

Did your accident occur while at work? Yes ☐ No ☐ When? ____________

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and Goes ☐

Please mark your areas of pain on the figures below.



____ Neck Problems	____ Sore Muscles	____ Allergies
____ Shoulder Problems	____ Walking Problems	____ Hay Fever
____ Arm Problems	____ Broken Bones	____ Asthma
____ Numbness-Arms	____ Muscle Cramps	____ Exzema
____ Pain Between Shoulders	____ Weak Muscles	____ Shingles
____ Low Back Problems	____ Headaches	____ Nausea
____ Leg Problems	____ Dizziness	____ Poor Digestion
____ Numbness-Legs	____ Fainting	____ Ulcers
____ Loss of Feeling	____ Forgetfulness	____ Diarrhea
____ Stiff Joints	____ Depression	____ Constipation
____ Painful Joints	____ Vision Problems	____ Kidney Infection
____ Restricts Daily Activities	____ Ear Pain/Noises	____ Mentrual Cramps
____ Restricts Regular Exercise	____ Ear Infections	____ Diabetes
	____ Hearing Loss	____ Blood Pressure High/Low
	____ Frequent Colds	____ Tiredness/Fatigue

- This is a new/old illness. It was not/was treated before. If treated before, what was done? ____________
- Name of Doctors: ____________
- Have you ever had surgery or been hospitalized? ☐ Yes ☐ No List Surgeries: ____________
- Have you ever had Chiropractic care before? ☐ Yes ☐ No Name of Doctor ____________ Date ________
- Last time you had spinal X-rays or other X-rays: ____________
- Medications you now take: ____________

From birth to present please list by date/describe

1) Car Accidents ____________

2) Falls/Injuries (Including Sports) ____________

3) Other ____________

(FOR DOCTORS USE ONLY)

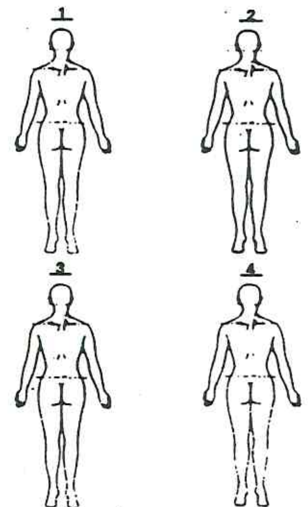
CERVICAL MOVEMENT

	Norm	Date 1____	2____	3____	4____
Flexion	45				
Extension	50				
Lat. R. Flex	70				
Lat. L. Flex	70				
Rotation Right	70				
Rotation Left	70				

DORSAL LUMBAR MOVEMENT

	Norm	Date 1____	2____	3____	4____
Flexion	60				
Extension	20				
Lat. R. Flex	20				
Lat. L. Flex	20				
Rotation Right	20				
Rotation Left	20				

	1____ L	R	2____ L	R	3____ L	R	4____ L	R
F. Compression								
Shoulder Depression								
Kemps								
Faber Patrick								
Soto Hall								
Bilat. Leg Lowering								
Ely's								
Short Leg								
Derefield Test								
Weight Distribution								
Dec. Int. Hip Rot.								
Dynanometer								



Comments ____________________

Height ______ Weight ______