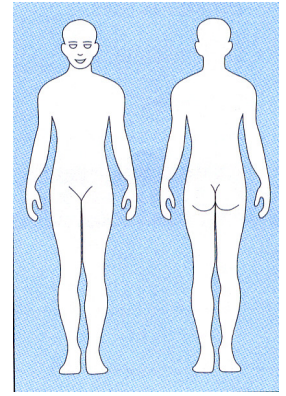


Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Date \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
 Best time and place to reach you \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
**CONTACT IN CASE OF EMERGENCY:** \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Would you like to receive our newsletter via email? Yes/no Email address: \_\_\_\_\_

Reason for Visit \_\_\_\_\_  
 When did your symptoms appear? \_\_\_\_\_  
 Is this condition getting progressively worse?  Yes  No  Unknown  
*Mark an X on the picture where you continue to have pain, numbness, or tingling.*  
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_  
 Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  
 Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  Other  
 How often do you have this pain? \_\_\_\_\_  
 Is it constant or does it come and go? \_\_\_\_\_  
 Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down  
 Does it interfere with your  Work  Sleep  Daily Routine  Recreation



What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  CranioSacral Therapy  None  Other \_\_\_\_\_

**Exercise:**  None  Moderate  Daily  Heavy  
**Work Activity:**  Sitting  Standing  Light Labor  Heavy Labor  Mixed  
**Habits:**  Smoking Packs/day: \_\_\_\_\_  Alcohol Drinks/Week: \_\_\_\_\_  
 Coffee/Caffeine Cups/Day: \_\_\_\_\_  High Stress Level Reason: \_\_\_\_\_

Injuries/Surgeries	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Surgeries	_____	_____
Birth Trauma/Injury	_____	_____
Do you have any pins or plates? _____ if yes, where? _____		

**Medication(s)**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Vitamins/Herbs/Minerals**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_