ARNOLD CHIROPRACTIC LIFE CENTER
Patient Information

Name_____**Date**_____
FIRST MIDDLE LAST

Address_____**City/State**_____**Zip**_____

Age_____**Birth Date**_____**Sex: ( )Male ( )Female Marital Status: S M D W**

Email Address_____**@**_____

Home Phone #_____**Work Phone #**_____**Mobile Phone #**_____

Name of responsible adult if the patient is a dependent child: _____ Relation: _____

Primary Insurance Company_____
(Please provide your insurance card and identification card so that we may verify your insurance coverage.)
Social Security Number _____ (not mandatory but sometimes necessary)

Who referred to our office? _____ How did you hear about us?_____

What is your occupation? _____

Reason for today's visit 1. _____ Date of Onset: _____

Reason for today's visit 2. _____ Date of Onset: _____

Reason for today's visit 3. _____ Date of Onset: _____

Has this happened before? ( )YES ( )NO When? _____

Does this interfere with your normal living and/or work? _____

Is there any family history of this condition? _____

Is your condition due to injury? ( )Yes ( )No. (If Yes): ( )Job Injury ( )Auto Injury ( )Sports Injury ( )Home Injury

Have you had treatment by another doctor for this condition? ( )YES ( )NO / By who? ( )M.D. ( )D.O. ( )D.C.

If yes, please provide the doctor's name. _____ Length of time under his/her care: _____

Treatment (Circle all that apply): X-Rays Blood Work Urinalysis MRI/CT Scan Medication Therapy Other

What were the results? _____

Check one: _____I want to regain and maintain normal health if possible.
_____I am healthy and I want relief only.

If the basic SPINAL cause of your condition is determined and if we accept your case for chiropractic care; check here if there are any reasons you may not complete the doctor's recommendations for recovery and health preservation _____.

If you may not complete your recommended care, please state your reasons here_____

_____

Signature _____ Date: _____

Witness _____ Date: _____

Confidential Health History

Habits

( ) Smoker: Pack/day _____
( ) Alcohol: 8oz/Day/week _____
( ) Coffee/Caffeine: 8oz/Day ____
( ) Sugar: ( ) Daily ( ) Weekly
( ) Drugs/Medications

Exercise

( ) None
( ) Light
( ) Moderate
( ) Daily
( ) Extreme

Family History

	Diabetes	Heart	Kidney	Cancer	Back Surgery
Mother	( )	( )	( )	( )	( )
Father	( )	( )	( )	( )	( )
Brothers	( )	( )	( )	( )	( )
Sisters	( )	( )	( )	( )	( )

Have you ever had any of the following diseases?

__ Appendicitis __ Amnesia __ Heart Disease __ Arthritis __ Influenza __ Pneumonia
__ Measles __ Mental Dis. __ Whooping Cough __ Tuberculosis __ Chicken Pox __ Diabetes
__ Cancer __ Alcoholism __ Venereal Infection __ Epilepsy __ Eczema __ AIDS

Please write an **"A"** next to the signs or symptoms you are **now** experiencing.
Please write a **"B"** next to the signs or symptoms you have experienced in the **past.**

Musculo-Skeletal
__ Lower Back Pain
__ Shoulder Pain
__ Neck Pain
__ Arm Pain
__ Arm Numbness/Tingling
__ Leg Pain
__ Leg Numbness/Tingling
__ Swollen Joints
__ Joint Pain
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Herniated Disc
__ Broken Bones
__ Tailbone Pain
__ Foot Trouble
__ Spine Pain

Genito-Urinary
__ Bladder Trouble
__ Excessive Urination
__ Scanty Urination
__ Painful Urination
__ Discolored Urine
__ Bed Wetting
__ No Urinary Control

Female Only
__ Vaginal Discharge
__ Vaginal Bleeding
__ Vaginal Pain
__ Breast Pain
__ Lumps in Breast
__ Pregnant (Y) (N)
__ Painful Periods
__ Irregular Cycle
__ Cramps

Gastro-Intestinal
__ Poor Appetite
__ Excessive Hunger
__ Difficult Chewing
__ Difficult Swallowing
__ Excessive Thirst
__ Nausea
__ Excessive Vomiting
__ Digestion Problems
__ Diarrhea
__ Constipation
__ Bloody Stool
__ Black Stool
__ Hemorrhoids
__ Liver Trouble
__ Gall Bladder Trouble
__ Weight Trouble
__ Food Allergies
__ Belching/Gas

Cardio-Vascular
__ Chest Pain
__ Pain Over Heart
__ Rapid Heart Beat
__ High Blood Press.
__ Low Blood Press.
__ Slow Heart Beat
__ Stroke
__ Poor Circulation
__ Varicose Veins
__ Fainting

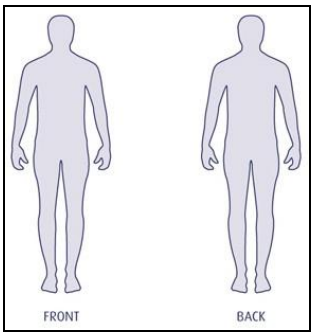
Nervous System
__ Numbness
__ Loss of Feeling
__ Paralysis
__ Dizziness
__ Fainting
__ Headaches
__ Muscle Jerking
__ Convulsions
__ Forgetfulness
__ Confusion
__ Depression
__ Loss of Sleep

Male Only
__ Prostate Trouble

Respiratory
__Shortness of Breath
__ Difficult Breathing
__ Persistent Cough
__ Coughing Phlegm
__ Lung Problems
__ Cold/Flu
__ Asthma
__ Wheezing
__ Coughing Blood

Eye/Ear/Nose/Throat
__ Eye Pain
__ Eye Strain
__Vision Trouble
__ Ear Pain
__ Ear Noises
__ Ear Discharge
__ Hearing Loss
__ Nose Pain
__ Nose Bleeding
__ Nose Discharge
__ Clogged Nose
__ Sore Gums
__ Dental Problems
__ Sore Mouth
__ Sore Throat
__ Hoarseness

Please mark your areas of pain. _____



Patient's Signature _____