Name (Last, first, m.):	Age:	Date of Birth_____/_____/_____
Address:		City, State, Zip
Cell Phone:	Home Phone:	Work Phone:
Email address:	Occupation:	Employer:
Sex: ☐ M ☐ F	Marital Status: ☐ M ☐ S ☐ D ☐ W	Children and ages:
Closest Relation:		Phone:
Who may we thank for your referral to this office?		

Your Health Profile

Please briefly describe the chief area of complaint, including the effect it has on you life.

My main complaint:_____
If you are experiencing pain is it: ☐ Sharp ☐ Dull ☐ Comes and goes ☐ Constant ☐ Burning ☐ Other
Since the problem began is it: ☐ About the same ☐ Getting worse ☐ Getting better ☐ Comes and goes
What makes it worse?_____
What makes it better?_____
It interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Standing ☐ Stairs ☐ Lifting ☐ Home life
I believe that the cause of my problem is:_____
I first noticed my problem:_____
Other doctors seen for this problem and what they did: ☐ Chiropractor_____
☐ Medical Doctor _____
☐ Other_____
Past Chiropractic care: When?_____ Who was your chiropractor?_____
Vitamins you take regularly and amounts:_____
_____

Your stress history

Please indicate whether you have <u>ever</u> experienced stress in the following areas. Your answers will enable us to determine which experiences have contributed to your present health concerns.

Your Birth, Infancy and Childhood Years

☐ Difficult or Prolonged Labor	☐ Fall/Jump from height < 3 feet; age_____
☐ Breech position and/ or C-section	☐ Fall/Jump from height> 3 feet; age_____
☐ Drugs during labor	☐ Car accidents; age_____
☐ Forceps/ Vacuum extraction	☐ Beating, Child abuse
☐ Ear Infections	☐ Youth sports, which; age_____
☐ Repeated antibiotic use; age_____	☐ Head Trauma
☐ Childhood illnesses:	☐ Broken bones
☐ Prescription Medications	☐ Other Traumas
☐ Inhaler use	☐ Regular chiropractic health care throughout childhood

Adult (18 to present)

☐ Smoking	☐ Contact/ Extreme Sports
☐ Coffee Drinker	☐ Alcohol/ Drug Abuse
☐ Car Accidents; when	☐ Fall/ Jump from a height
First day of your last menstrual period_____/_____/_____	Could you possibly be pregnant? ☐ Yes, ☐ No
Your Height: _____	Your Weight: _____

Your Health History

Please check off all symptoms or conditions that you have experienced. Circle those symptoms that you currently are experiencing.

- ☐ Allergies, Asthma
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/ Bronchitis
- ☐ Arm pain
- ☐ Back Pain
- ☐ Cancer, Type_____
- ☐ Circulatory Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea, Constipation
- ☐ _____
- ☐ Digestive Problems
- ☐ Dizziness, Vertigo
- ☐ Frequent Colds
- ☐ Headaches, Migraines
- ☐ Heart Conditions
- ☐ Hip pain
- ☐ Immune System Disorders
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Severe Menstrual Symptoms, Cramps
- ☐ Leg pain
- ☐ _____
- ☐ Neck Pain/ Stiffness
- ☐ Numbness in hands and/or feet
- ☐ Osteoporosis
- ☐ Shoulder pain
- ☐ Sinus Problems
- ☐ Sleep Problems/ Insomnia
- ☐ Stroke or TIAs
- ☐ Tingling (Pins and needles) in arms and/or legs
- ☐ TMJ (Jaw) Problems
- ☐ Urinary Problems
- ☐ Yeast Infections
- ☐ _____

Are there any other health concerns that we should be aware of? ☐ No ☐ Yes_____

_____

Are you pregnant or breastfeeding? ☐ Yes, ☐ No
Do you have problems sleeping? ☐ Yes, ☐ No; Why?_____
What position do you sleep in? ☐ Side, ☐ Back, ☐ Stomach
Do you exercise regularly? ☐ Yes, ☐ No; If yes, what exercise do you enjoy?_____

List previous surgeries and dates

Medications (prescription and over the counter): ☐ Pain Meds ☐ Anti-inflammatories ☐ Birth control ☐ Heart Meds ☐ Cholesterol Meds

☐ Antidepressants ☐ Other_____ Prescribed by_____

Chiropractic Defined

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal it-self without the use of drugs or surgery.

The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.

I understand that the chiropractors in this office provide chiropractic adjustments to treat musculoskeletal complaints. I understand that all charges are due and payable at the time of service until I have provided insurance information that will cover all charges.

_____ _____/_____/_____
Signature Date

I hereby give permission for Dr. Lundquist and Dr. Patterson to care for my minor child as they deem necessary.

_____ _____/_____/_____
Signature Date