

Welcome to the Hands of Healing Chiropractic Centre'

Please Print Clearly and fill In completely.

Print Name _____ Email _____

Circle one: Dr./Mr./Mrs./Ms./Miss

Street Address _____ Home Phone _____

Cell Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Please Check ✓ Sex: M F Right handed Left handed Married Single Separated Divorced

Health History:

Give reason for seeking chiropractic care: _____

Describe any health problems, including how long you've had them: _____

Are you under the care of any other doctor? Yes No

If Yes, the conditions being treated for: _____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Work Duties _____

Female: How many children? _____ Natural birth: Yes/No C-Section: Yes/No Pitocin given? Yes/No

Forceps Delivery: Yes/No Stillbirth(s): _____ Abortion(s): _____

Explain with other details relating to any pregnancy, especially any complications, etc.: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes No If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Family History: List family history of inherited conditions: e.g.: Cancer/Diabetes/etc.

Who referred you?

FEMALES: Please Check One ✓ Is there a possibility of you being pregnant? Yes No

Please turn over & complete the back portion

Please Fill in Below If you have had the following, or if you suffer from the following. ***Please Check*** ✓

| Condition, Symptom Or Problem | Constantly or Frequently | Sometimes or Occasionally |
|-------------------------------|--------------------------|---------------------------|
| Headache | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm/Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Disc Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Other joint pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervousness | <input type="checkbox"/> | <input type="checkbox"/> |
| Insomnia | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent colds | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose Bleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> |
| Earaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Female problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinary Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin conditions | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Circle the areas where you have any problems. Please also describe these problems.

Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

INSURANCE INFORMATION:

Name of Insurance Company:

Thank you for being complete and thorough.

Your Signature Below Please

X _____

Date: _____