ADVANTAGE CHIROPRACTIC

Dear Patient,
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do sincerely believe your condition will respond satisfactorily, we will accept your case. Thank you.

Last Name_____ First Name _____Middle Initial ____

Address_____City_____State_____Zip_____

Home Telephone ( ) _____Cell Number ( )_____

What you prefer to be called_____ How were you referred to us?_____

Employer/Occupation_____ Work Number( )_____

Sex: (M)____(F)____ Birth date: ____/____/_____ Age: ____

Marital Status: M S W D Spouse's Name: _____ Number of Children____

Nearest Relative: _____Telephone # ( )_____

Name of Primary Physician: _____Telephone # ( )_____

Email Address: _____

Have you ever seen a Chiropractor before? **Y N** If yes, when and who? _____

HEALTH INFORMATION

What is your major complaint? _____

Other complaints? _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

What areas of your life have been affected by your pain and symptoms? _____

_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes____No_____Constant_____Comes and Goes_____

Is this condition interfering with your: Work____Sleep____Daily routine____Other_____

How long has it been since you've felt good? _____

List other doctors who have treated this condition_____

List surgical operations and years_____

_____

Are you pregnant? Yes___ No___ How far long? _____

Age of Mattress_____Comfortable_____Uncomfortable_____

Are you wearing: Heel lifts_____ Sole lifts_____ Inner soles_____ Arch supports_____

Have you been in an Auto Accident? Past year_____ Past 5 years_____ Over 5 years_____

Describe: _____

_____