

Emerald Coast Chiropractic

Please print clearly and fill in completely

Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____
Date of Birth _____ SSN# _____
E-mail _____
Marital Status (circle one) Single Married Other # of Children _____

Whom may we thank for referring you to our clinic? _____

Your Occupation _____
Your Employer _____ Work Phone _____
Spouse's Name _____
Spouse's Employer _____ Work Phone _____

Insurance Information

Insurance Company _____ Phone Number _____
Member/Subscriber Name _____ ID/Member Number _____

Health History

Give reason for seeking chiropractic care _____
Date of Accident/Onset _____
Is this condition due to a/an (circle one) Auto Accident Work Injury Other
Are you under the care of any other doctor? Yes No If yes, the condition being treated for?

List any current medications: _____
List any past surgeries and dates: _____
List any past accidents and dates: _____
List any x-rays you've had in past 2 years: _____

Chiropractic History

Have you ever been to a chiropractor before? Yes No
If Yes, Doctor's Name _____ Location _____
Date of last visit _____ Reason for care _____
Are other family members under chiropractic care? Yes No Who? _____

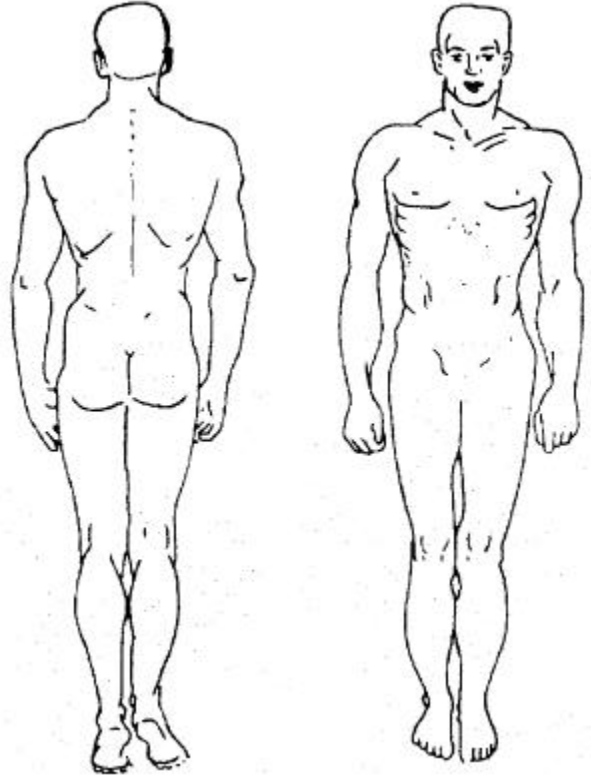
FEMALES: Is there any possibility of you being pregnant? Yes No

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

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

Please circle areas of pain or discomfort



Please rate your pain on a scale from 1 to 10
 0 1 2 3 4 5 6 7 8 9 10

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

Thank you for being complete and thorough.
Your Signature Below Please

Date: _____