



Tell us about Yourself

Name _____ Date _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Cell-Phone _____ Which do prefer we call? _____

Age _____ Birthday _____ SSN _____

Referred by _____ Occupation _____

Describe your hobbies _____

Describe your work activities _____

Employer _____ Marital Status _____

Spouse's Name _____ Spouse's Occupation _____

Emergency Contact Information

Name _____ Relation _____

Phone number _____ Address _____

City _____ State _____ Zip _____

Insurance Information

Insurance Company _____

Name of Insured _____ Relation to you _____

Identification number _____

Group Number _____

Your Health Attitude

Please mark which one applies to you

___ **Pain Relief** – I only consult with a doctor when I am in pain. I discontinue treatment as soon as it has cleared up.

___ **Prevention** - In addition to symptomatic treatments, I consult with doctors to keep problems from appearing or re-occurring.

___ **Maximizing Health and Wellness** – I actively pursue health so I can feel better and perform better. So I can be the best I can be.



Medical History

To rule out disease as well as determine if you are healthy enough to be adjusted.

Please Explain

Date

Have you ever had any...

Injuries? _____

Surgeries? _____

Broken Bones? _____

Dislocations? _____

Auto Accidents? _____

Have you been diagnosed with any disease? _____

Hospitalizations? _____

Do you take any Medications? _____

Do you take them regularly? _____

Do you take Supplements? _____

Do you take them regularly? _____

Other? _____



Weimer Chiropractic

We Care. We get Results



Do you have, or have you ever had... (Please circle and explain below)

- | | |
|---------------------------|-------------------------|
| 1. HIV/ AIDS | 24. Alcoholism |
| 2. Anemia | 25. Anorexia |
| 3. Appendicitis | 26. Arthritis |
| 4. Bleeding Disorders | 27. Breast Lump |
| 5. Bronchitis | 28. Bulimia |
| 6. Cancer | 29. Cataracts |
| 7. Chemical Dependency | 30. Depression |
| 8. Diabetes | 31. Epilepsy |
| 9. Glaucoma | 32. Goiter |
| 10. Gout | 33. Heart Disease |
| 11. Hepatitis | 34. Hernia |
| 12. High Cholesterol | 35. Pacemaker |
| 13. Kidney Disease | 36. Liver Disease |
| 14. Osteoporosis | 37. Prostate Problems |
| 15. Stroke | 38. Tuberculosis |
| 16. Tumors | 39. Dizziness |
| 17. Drop attacks | 40. Ears Ringing |
| 18. Headache | 41. Artificial Joints |
| 19. High Blood Pressure | 42. Fainting |
| 20. Double vision | 43. Slurred Speech |
| 21. Chest pain | 44. Nagging Cough |
| 22. Difficulty swallowing | 45. Drooping of eyelids |
| 23. Change in pupils | |

<u>Number</u>	<u>Please Explain any of the above.</u>	<u>Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Do you have a family history of... (Please list the person's relation to you)

Cancer? _____

Heart Disease? _____

Stroke? _____

Diabetes? _____

Sign _____ **Date** _____



Chief Complaint

Give us information about how we may help you.

Name _____ Date _____

What is your main complaint today? _____

How long have you had this condition? _____

How did this begin? _____

What makes it better? _____

What makes it worse? _____

Is it constant or does it come and go? _____

Is there a part of the day when the condition is better? _____

How many times per day or week do you feel it? _____ per day/week/month

If there is pain involved....

On a scale of 1-10 (10 being the worst) How would you rate this pain? _____

Please mark the area of complaint on the body diagram using the appropriate symbols.

Please indicate the area of pain or unusual feeling using the symbols below.

Sharp = *****

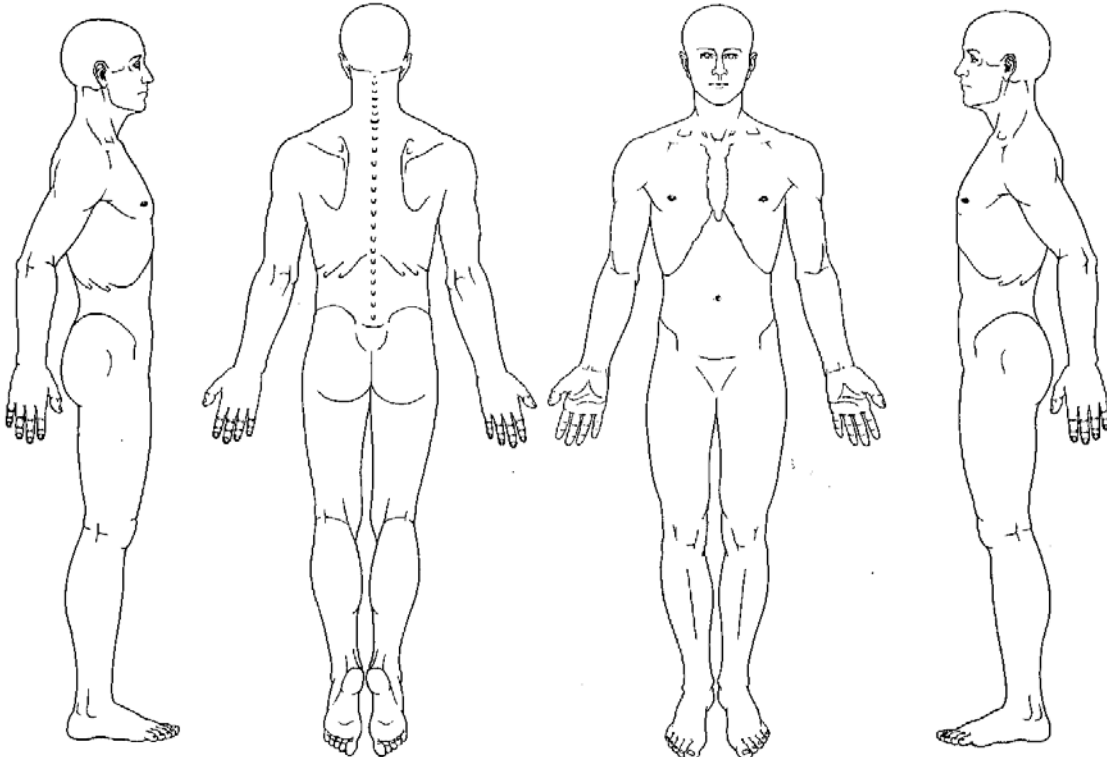
Dull = ^^^^^^^^^^^^^

Achy = AAAAAAA

Burning = BBBBBBB

Tingling = //////////////

Numb = XXXXXXX





Additional Complaints

Please tell us any additional things we can help you with.

Name _____ Date _____

What is your additional complaint? _____

How long have you had this condition? _____

How did this begin? _____

What makes it better? _____

What makes it worse? _____

Is it constant or does it come and go? _____

Is there a part of the day when the condition is better? _____

How many times per day or week do you feel it? _____ per day/week/month

If there is pain involved....

On a scale of 1-10 (10 being the worst) How would you rate this pain? _____

Please mark the area of complaint on the body diagram using the appropriate symbols.

Additional Complaints

What is your additional complaint? _____

How long have you had this condition? _____

How did this begin? _____

What makes it better? _____

What makes it worse? _____

Is it constant or does it come and go? _____

Is there a part of the day when the condition is better? _____

How many times per day or week do you feel it? _____ per day/week/month

If there is pain involved....

On a scale of 1-10 (10 being the worst) How would you rate this pain? _____

Please mark the area of complaint on the body diagram using the appropriate symbols.