Welcome to Baker Chiropractic

Today's Date _____/_____/_____

First:_____Middle:_____Last: _____Birth Date: _____ /_____/_____

Sex: ☐ Male ☐ Female How did you hear about us?_____Email: _____

Address: _____Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name:_____Children (names and age):_____

Emergency Contact Name: _____Relation_____Phone: (_____)_____-_____

HEALTH HISTORY

Give reason for seeking chiropractic care_____

_____

How long have you had this condition? _____Have you had it before?_____

Is this a result of a(n): ☐ auto accident ☐ work injury ☐ unknown cause ☐ other_____

Rate your overall discomfort by circling the number below:

Not much discomfort 0 1 2 3 4 5 6 7 8 9 10 extreme discomfort

Discomfort is (check all that apply) ☐constant ☐comes and goes ☐ radiates ☐ sharp/stabbing ☐ dull/achy

What activities aggravate your condition? _____

What relieves your condition? _____

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

_____

Are you under the care of any others doctor ☐ Yes ☐ No If Yes, conditions being treated for:_____

_____

List any current medications:_____

List any past surgeries and dates:_____

List any past accidents and dates:_____

List any X-rays/MRIs you've had in the past 2 years:_____

PERSONAL & FAMILY HISTORY

Your occupation_____work duties_____

Do you exercise? ☐ Yes ☐ No How often?_____What types of exercise?_____

Parents Health Status_____

Spouse's Health Status_____

Children's Health Status_____

CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? ☐ Yes ☐ No Chiropractor's name_____

Date of last chiropractic visit_____Reason for Care_____

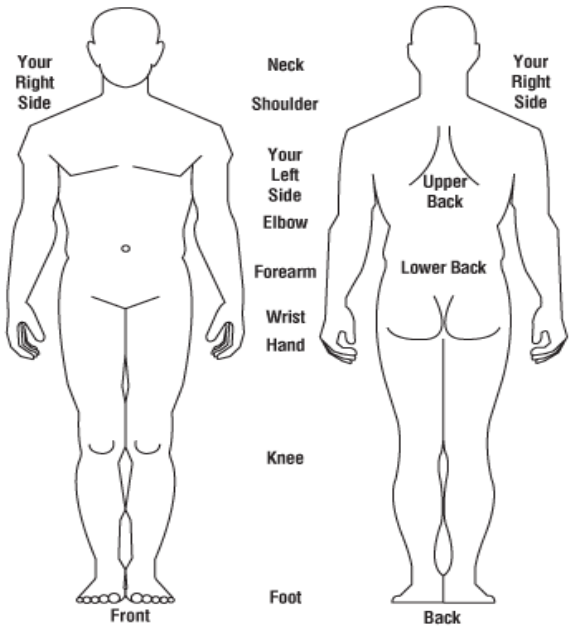
Date of last chiropractic X-rays_____How long were you under care_____

Are there other family members under chiropractic care? ☐ Yes ☐ No Who?_____

Please check off below if you have had the condition, symptom or problem within the last two years.

Condition, symptom or problem	Constantly or frequently	Sometimes or occasionally
Headaches	☐	☐
TMJ	☐	☐
Hearing problems	☐	☐
Thyroid conditions	☐	☐
High blood pressure	☐	☐
Numbness in arms/hands	☐	☐
Pain in shoulders/arms/hands	☐	☐
Recurrent colds/flu	☐	☐
Dizziness	☐	☐
Allergies/hay fever	☐	☐
Tingling in arms/hands	☐	☐
Weakness in grip	☐	☐
Visual disturbances	☐	☐
Low energy/fatigue	☐	☐
Midback/shoulder blade pain	☐	☐
Asthma/wheezing	☐	☐
Pain w/ deep breath	☐	☐
Indigestion/heartburn	☐	☐
Tired irritable when hungry	☐	☐
Bronchitis	☐	☐
Shortness of breath	☐	☐
Heart conditions	☐	☐
Pain in ribs/chest	☐	☐
Hypoglycemia	☐	☐
Diabetes	☐	☐
Heart palpitations	☐	☐
Ulcers/gastritis	☐	☐
Low back pain	☐	☐
Numbness in legs/feet	☐	☐
Frequent /difficult urination	☐	☐
Cramps in legs /feet	☐	☐
Injury to hip/legs/feet	☐	☐
Pain in hips/legs/feet	☐	☐
Coldness in legs/feet	☐	☐
Recurrent bladder infections	☐	☐
Menstrual irregularities/cramping	☐	☐
Tingling legs/feet	☐	☐
Weakness in legs/feet	☐	☐
Sciatica	☐	☐

Please circle any areas where you have problems.



Below, please fill in any other health information you feel we might need to know for your care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

X_____

Date:_____