INITIAL HEALTH FORM

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

Last Name | First Name

Address: | City | Zip Code

Home# | Work | Cell# | Sex:M/F

Email | Referred By

D.O.B | Age | Height | Weight

Occupation | Employer

Name of Spouse | Children's Name & Ages:

Reason of Appointment

When did your condition begin?

Have you ever had similar problems?

- ☐ Yes
- ☐ No

Have you had X-rays, MRI or other tests for this condition? What tests a

Is this condition related to: Work?

- ☐ Yes
- ☐ No

Has your employer been notified?

- ☐ Yes
- ☐ No

Motor vehicle accident?

- ☐ Yes
- ☐ No

Date of injury

Can you perform your daily home activities?

- ☐ Yes
- ☐ Yes, only with help
- ☐ Not at all

Can you perform your daily work activities?

- ☐ All activities
- ☐ Only some
- ☐ Not at all

Describe your stress level: *

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ High

Do you exercise?

- ☐ Daily
- ☐ Occasionally
- ☐ Not at all

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):

Have you had previous chiropractic care? *

- ☐ Yes
- ☐ No

Doctor | Date

Family doctor name:

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.)

Date | Practice Member Signature: