

MOUNTAIN MEADOW CHIROPRACTIC

Name: _____ Email Address: _____

If practice member is a minor, parent name(s): _____

Date of Birth: ____/____/____ Age: _____ Male / Female Today's Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Preferred Method of Communication (check one): Email Text Cell Phone Home Phone

Occupation: _____ Student / Full Time Parent / Retired From: _____

Employer's Name: _____

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

Names, Ages & Gender: _____

****WOMEN ONLY**** For x-ray purposes, is there any possibility that you could be pregnant? YES / NO

If yes, how far along? _____ Due Date: _____

Who may we thank for referring you? _____

WHAT BRINGS YOU IN TODAY? PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HAVE YOU SEEN ANY MEDICAL DOCTORS FOR THESE CONDITIONS? YES / NO

IF YES, WHEN? _____

HAVE YOU PREVIOUSLY SEEN A CHIROPRACTOR? YES / NO DATE OF LAST SPINAL XRAYS: _____

IF YES, WHO AND WHEN WERE YOU LAST ADJUSTED? _____

LIST ALL SURGICAL OPERATIONS AND YEARS:

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU TAKE / LAST ROUND OF ANITBIOTICS (DATE)

LIST ALL TRAUMAS (AUTO ACCIDENTS, SLIPS, FALLS, SPORTS, EXERCISE) AND DATES:

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO

FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE: _____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE

CANCER

HEART DISEASE

SPINAL SURGERY

SEIZURES

SPINAL BONE FRACTURE

SCOLIOSIS

DIABETES

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

DIZZINESS/VERTIGO

TMJ / JAW PAIN

MID BACK PAIN

LOW BACK PAIN

DISC PROBLEMS

HEADACHES

SHOULDER PAIN

NUMBNESS IN ARMS

NUMBNESS IN LEGS

HIP/PELVIC PAIN

NECK PAIN

ARM PAIN

NUMBNESS IN HANDS

NUMBNESS IN FEET

SCIATICA

MUSCLE SPASMS

MUSCLE WEAKNESS

KNEE PAIN

LEG PAIN

SCOLIOSIS

NAUSEA

SINUS ISSUES

CHEST PAIN

MENSTRUAL CRAMPS

BLADDER PROBLEMS

ANXIETY

RINGING IN EARS

HEART DISORDERS

MENSTRUAL IRREGULARITY

PLANTAR FASCIITIS

DEPRESSION

THROAT ISSUES

HIGH/LOW BLOOD PRESSURE

INFERTILITY/MISCARRIAGE

SHORTNESS OF BREATH

NERVOUSNESS

THYROID ISSUES

ALLERGIES

KIDNEY PROBLEMS

FREQUENT COLDS

EPILEPSY/SEIZURES

EAR INFECTIONS

CHRONIC FATIGUE

ASTHMA

FIBROMYALGIA

ADD/ADHD

INSOMNIA

DIGESTIVE ISSUES

LIVER DISEASE

VISION CHANGES

ARTHRITIS

ECZEMA/RASH

ACID REFLUX/ULCERS

PROSTATE ISSUES

SWELLING IN JOINTS

SOCIAL HISTORY | DO YOU...

SMOKE? YES / NO HOW OFTEN? _____

EXERCISE? YES / NO HOW OFTEN? _____, MILD / MODERATE / INTENSE

HOW DOES YOUR CURRENT PROBLEM AFFECT YOUR FAMILY LIFE, WORK, HOBBIES, ETC?

WHAT ARE YOUR HEALTH GOALS? HOW WILL THEY CHANGE YOUR LIFE ONCE ATTAINED?

BIRTH & CHILDHOOD HISTORY

How were you (the patient) born?

Any complications during your birth process or mother's pregnancy?	YES / NO	Details:																						
Type of birth:	C-Section	Vaginal	How long was labor and delivery?																					
What did the care provider use to assist in delivery?	Hands	Vacuum	Forceps	Unassisted																				
Were you vaccinated?	YES / NO	List any reactions/injuries (ex: fever):																						
Did you have any early health challenges?	YES / NO	Details:																						
Did you have any concerning trips or falls?	YES / NO	Details:																						
List any over-the-counter or prescription medications frequently used as a child	YES / NO	Details:																						
Did your parents worry often about your health?	YES / NO	Due to health issues, did you miss school and other activities?	YES / NO	Details:																				
<p><u>Circle all symptoms you experienced as a child:</u></p> <table style="width: 100%; border: none;"> <tr> <td>Trouble Sleeping</td> <td>Ear Infection</td> <td>Colic/Reflux</td> <td>Allergies</td> <td>Abnormal Skull Shape</td> </tr> <tr> <td>Frequent Tantrums</td> <td>Bedwetting</td> <td>Fevers</td> <td>ADHD</td> <td>Trouble Concentrating</td> </tr> <tr> <td>Weak Heartbeat</td> <td>Racing Heart</td> <td>Murmur</td> <td>Torticollis</td> <td>Digestive Problems</td> </tr> <tr> <td>Breathing Problems</td> <td>Birth Trauma</td> <td>Seizures</td> <td>Asthma</td> <td>Known Vaccine Reaction</td> </tr> </table> <p>Other: _____</p>					Trouble Sleeping	Ear Infection	Colic/Reflux	Allergies	Abnormal Skull Shape	Frequent Tantrums	Bedwetting	Fevers	ADHD	Trouble Concentrating	Weak Heartbeat	Racing Heart	Murmur	Torticollis	Digestive Problems	Breathing Problems	Birth Trauma	Seizures	Asthma	Known Vaccine Reaction
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FAMILY HISTORY

CONDITION	MOTHER	FATHER	CHILDREN	SPOUSE
Arthritis				
Asthma/Allergies/Sinus Trouble				
ADD/ADHD				
Bed Wetting				
Cancer				
Carpal Tunnel				
Deceased				
Diabetes				
Digestive Problems/Heartburn				
High Blood Pressure				
Ear Infections				
Fibromyalgia				
Headaches/Migraines				
Neck Pain/Back Pain/Disc Problems				
Menstrual Problems				
Scoliosis				
TMJ				