



Patient _____
Doctor Boda _____
Date _____ Case # _____

Name _____ Preferred Name _____
Address _____
City/State/Zip _____
Phone #s (Home) _____ (cell) _____
Is it okay to contact you at work? no yes Work # _____
E-mail address _____ Web site _____
SS# _____ Birth Date _____ Age _____
Occupation _____ Employer _____
Marital Status single married separated widowed
Spouse's name _____ Phone # (s) _____
Children's name and age's _____

Emergency contact: Name _____
Relationship _____ Phone #(s) _____

What Brings You Here?

Have you ever had chiropractic care before? no yes
If yes, please tell us the Doctor's name _____
Were you pleased with your care? no yes

How did you find out about our office? _____

Is this appointment related to work sports auto
 Personal injury other _____

When did the incident occur? _____
Attorney (if applicable) _____ Phone _____

Are you receiving care from other health professionals? no yes
If yes, please name them and their specialty _____

Please list any drugs or medications you are taking _____

Please list any vitamins/herbs/homeopathic/other you are taking _____

Are you pregnant? no yes If yes, what month? _____

Current Health

What are your most pressing concerns?

For how long? _____

Is it getting worse improving intermittent constant can't say

Where is the problem? Please use the lines below to explain.

Front _____

Back _____

Do you have pain numbness tingling aches

Is your pain sharp dull throbbing constant intermittent

Are your symptoms sitting standing walking

Affected by bending lying down weather

Please explain _____

Do you feel cramps burning other _____
 swelling stiffness

Do your symptoms work sleep other _____
interfere with day-to-day activities play

Please explain

On a scale 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Do you have, or have you had, any of the following (please check all that apply)

- pneumonia mumps influenza rheumatic fever small pox
- pleurisy polio chicken pox thyroid disease diabetes
- epilepsy cancer depression whooping cough anemia
- eczema measles arthritis heart disease rashes

If you have ever been diagnosed with another disease or condition, please describe _____

Do you use coffee tea artificial sweeteners sugar
 alcohol cigarettes

Have you ever suffered from (please check all that apply)

- neck pain stuffy nose discolored urine
- low back pain allergies gas/bloating after meals
- headache fainting heartburn
- migraines weight loss colitis
- arm back/tingling poor appetite irritable bowel
- shoulder pain excessive appetite black or bloody stools
- hand pain/tingling nervousness constipation
- leg pain/tingling confusion hemorrhoids
- jaw pain depression liver problems
- chest pain dental problems stroke
- lung problems excessive thirst paralysis
- heart problems frequent nausea tingling
- abnormal blood pressure vomiting numbness
- irregular heartbeat prostate problems fatigue
- ankle swelling breast pain/lump dizziness
- cold extremities cramps loss of sleep
- blurred vision painful urination difficulty hearing
- vision problems bladder trouble ear pain
- difficulty breathing excessive urination

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check all that apply)

- falls/accidents head injuries fights
- sports injuries broken bones dislocations
- spinal tap surgery traction
- use(d) a cane or walker extensive dental work dental appliances
- knocked unconscious

If yes to any of the above, please describe _____

Are there any other health concerns or anything else you'd like us to know about you?

no yes If yes, please tell us _____

Notes: _____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care?

Cash Check Credit Card # _____ Exp. _____

The above is accurate to the best of my knowledge.

(Signature)

(Date)

I, parent/guardian, give permission for minor's care.

(Signature)

(Date)