Patient Name:							
Address:							
Apt/Suite:	City:						
State:				Zip Code:			
Email:				@ .com			
Social Security #:			Home Ph:				
Date of Birth:			Cell Ph:				
Age:			Work Ph:				
May we con	tact you by phone a	nd leave a	message?		Yes	or	No
Employer:							
Occupation:							
Spouse's Name:							
Spouse's Employer:			Work Ph:				
Emergency Contact:	Who may we thank for referring you to our office?						
			VVIIO	may we ma	TIK TOT TOTOTTI	ig you to ou	ii oilico:
Emergency Contact #:							
Marital Status:	Single		Married Divo		rced	Widow(er)	
Race:	White	Black/African		American		American/Alaskan Indian	
	Patient Declined to Answer						
Ethnicity:	Hispanic/Latino Not Hispanic/Latino						0
Preferred Language:	English	F	rench	Spanish		Italian	
	Chinese	Ja	Japanese Russian		sian	Portuguese	
Present Complaint:	What is the reason for your visit today? (Be Brief)						
Area of major complaint:							
Pain/Problem began on:							
Pain(s) are:	Dull	Achy	Sharp	Stabbing	Shooting	Deep	Throbbing
Pain(s) frequency is:	Intermittent		Occassional		Frequent		Constant
What activites lessen your co	_						
What activites aggravate your	_	<u> </u>					
Is your condition worse during		y ?	Cloop?		Routine?		
Is this condition interfering wit Is this condition getting progre	_		Sleep?		- Routine?		
Other Doctors seen for this co	•		-				
Any home remedies?							
Upon the completion of your first vis	sit vou will receive a Chi	ronractic Re	nort to discuss the d	ifferent types o	of Activa Lifa Pl	ans that are a	vailable to
you. Chiropractic Active Life Plans	•	•	•	• •			
Please review the explanations of the		,			•	, ,	
participation that supports you in re			, ,		,		
		-	iropractic care, I	would like to	):		
Feel better quickly  Have a healthier body by keeping my nerve system healthy							althy
Have a healthier spine			Live a healthier lifestyle				
	Signature			·		Date	