MyChiro FLOREAT

Personal Information

Full name: _____ Phone: _____

Address: _____

Email: _____

Date of Birth: _____ Age: _____

Occupation: _____

Number of Children: _____ Pregnant? Y/N Due Date: _____

Spouse/Guardian Name: _____

Who may we thank for referring you? _____

Health Concerns

What is your reason for todays visit? Please explain below:

_____

_____

☐ Spinal Check-up/Wellness Evaluation ☐ I have pain or another symptom (please describe)

_____

On a scale of 1 – 10 please rate your current pain level (please circle): 1_2_3_4_5_6_7_8_9_10

Is your pain sharp or dull, does it radiate anywhere? _____

What relieves your condition? _____

What aggravates your condition? _____

Have you seen any other practitioners for this condition? _____

Do you have any significant family history of your current condition? Or any other serious illness?

_____

Is this condition interfering with any of the following?

☐ Work ☐ Sleep ☐ Recreation ☐ Sports/Exercise

☐ Self-care ☐ Energy ☐ Attitude ☐ Patience

☐ Creativity ☐ Productivity ☐ Relationships ☐ Other

Have you experienced any of the following in the last 6 months (Please Tick)

☐ Low Back Pain ☐ Headaches ☐ Migraines ☐ Pins and Needles

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☐ Sinus Problems	☐ Fever	☐ Cold Sores	☐ Dizziness
☐ Double vision	☐ Fainting	☐ High Blood Pressure	☐ Problems Swallowing/Talking
☐ Numbness	☐ Nausea	☐ Unsteadiness on Feet	☐ Unexplained Weight Loss
☐ Night Sweats	☐ Fatigue	☐ Night Pain	☐ Sleeping Difficulties

General Health History

List any medications or supplements you take: _____

_____

Please list any surgical operations and the year they were performed: _____

_____

Please list any broken bones/fractures: _____

Have you had any accident and or injuries – vehicle, work or other:_____

_____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee is due at the time of service and cannot be deferred to a later date.

Patient Name: _____

Signature: _____

Date: _____