

Cornerstone Chiropractic Inc. PS

Please Print Clearly and Fill In Completely

Welcome to Cornerstone Chiropractic! Thank you for choosing our practice for your Chiropractic needs! If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Nickname _____ Date _____
Home Address _____ Apt. # _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Date of Birth _____ Age _____ Male Female ♦ Single Married Divorced Widowed
Student: Full time Part time Non-student Social Security # _____
Employer _____ Occupation _____ Full time Part time
Employer's Address _____ City, State, Zip _____
Name of Spouse _____ Spouse's Birth Date _____
Spouse's Employer _____ Social Security# _____
Name and Age of Children _____
Person to contact in case of Emergency: _____ Phone _____
How did you hear about our clinic? _____
Have you ever been to a Chiropractor before? Yes No If yes, Doctor's Name _____
Date of last Chiropractic Visit _____ Reason for Care _____
Date of last Chiropractic X-rays _____ How long were you under care? _____
Are other family members under Chiropractic care? _____

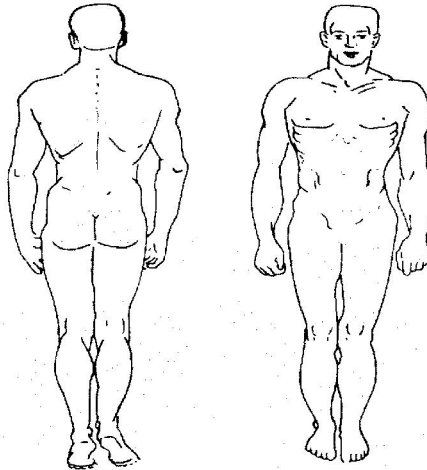
Reason for this visit: _____

Is this related to: Auto Accident Employment Accident Other Accident

Name and address of other doctor(s) who have treated you for this condition: _____

Please mark the areas of your pain on the diagram below. Use the following letters to indicate the type and location of your pain.

- A=Ache
- B=Burning
- P=Pins and Needles
- S=Stabbing
- N=Numbness
- O=Other



Review of Systems:

Check only those conditions that currently apply to you. **Underline** any conditions you have had in the past.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Numbness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Hand pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Low Back pain | <input type="checkbox"/> Loss of Smell/Taste | <input type="checkbox"/> Cough | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Leg pain | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Female Problems |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Foot pain | <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Hardening of Arteries | <input type="checkbox"/> Sexually Trans. Disease |
| <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Other Joint Pain | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Muscle Spasm | <input type="checkbox"/> Glaucoma/Cataracts | <input type="checkbox"/> Hypoglycemia | _____ |

Medical and Family History:

Please list all medications you are currently taking and the condition you are taking the medication for:

Medication _____ for _____

Medication _____ for _____

Medication _____ for _____

List past Surgeries and Dates _____

List past Accidents/Traumas and Dates _____

Allergies _____

List any X-rays you have had in the last 2 years _____

List any diseases/conditions of family members (Heart disease, Stroke): _____

Females: Are you pregnant? Yes No Date of last Period _____ Birth Control Pills Yes No

Height _____ Weight _____

Social History and Daily Habits:

Do you sleep on your: Back Right Side Left Side Stomach

Do you exercise? Yes No Type of Exercise _____ Frequency _____

Do you smoke? Yes No How much per day? _____

Do you drink alcohol? Yes No Frequency and Amount _____

Do you drink coffee/tea/cafeinated beverages? Yes No Quantity _____

What do your daily work habits include? (Ex. Sitting, Standing, light labor, heavy labor, computer work)

Hobbies: _____

I understand the above and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any change in my health status.

Patient Signature _____ Date _____

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