Ocean LightForce® Chiropractic
425-1421

OFFICE USE ONLY:

Date _____ ID#_____

Personal History

Name:_____ Birth Date:_____ Sex: Male Female

Address:_____ City:_____

State/Prov:_____ Zip/Postal Code:_____ Home Phone:_____

Cell Phone:_____ E-mail Address:_____

Social Security #:_____ Referred to this office by: _____

Employer:_____ Type of Work:_____

Business Phone:_____ Circle One: Married Single Other

Spouse's Name:_____ Type of Work:_____

Names and Ages of Children:_____

Emergency Contact: _____ Phone #:_____

Insurance Information

Health Insurance Company:_____ Insured Person's Name:_____

Group#:_____ ID#:_____ Contact Information: _____

Please bring any pertinent health insurance cards with you on your first visit.

Current Health

Unwanted Health Condition:_____

Have you seen another Doctor for this condition? ____Yes ____No - Who?_____

Treatment:_____ Results:_____

When did the condition begin?_____ Has this condition occurred before? ____Yes ____No

Is the condition the result of: ____Auto Accident ____Work Accident ____Home Injury ____Fall ____Other_____

Date of Accident: _____

Drugs you take: ____Nerve Pills ____Pain Killers/Muscle Relaxers ____Blood Pressure Medication ____Insulin

Other Prescription/Over the Counter Medication:_____

Do you wear a shoe lift? ____Yes ____No

Do you suffer from any conditions other than that for which you are now consulting us?_____

_____

Health History

Major Surgery/Operations: ____Appendectomy ____Tonsillectomy ____Gall Bladder ____Hernia ____Back Surgery ____Broken Bones

____Other:_____

Major Accidents or Falls:_____

Any Other Hospitalization:_____

Have you been under Chiropractic Care before? ____Yes ____No

Chiropractor's Name:_____ Approximate Date of Last Visit:_____

Symptoms

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST 6 MONTHS:

Musculo-Skeletal System

- ☐ Low Back Pain
- ☐ Pain Between the Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness

Nervous System

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness/Confusion
- ☐ Depression
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

General

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

FEMALES ONLY:

Are you pregnant? ____Yes ____No ____Not Sure

PLEASE OUTLINE ON THE DIAGRAM THE AREA(S) OF DISCOMFORT AND DESCRIBE BELOW

Please Describe Areas Indicated:

_____

_____

_____

_____

_____

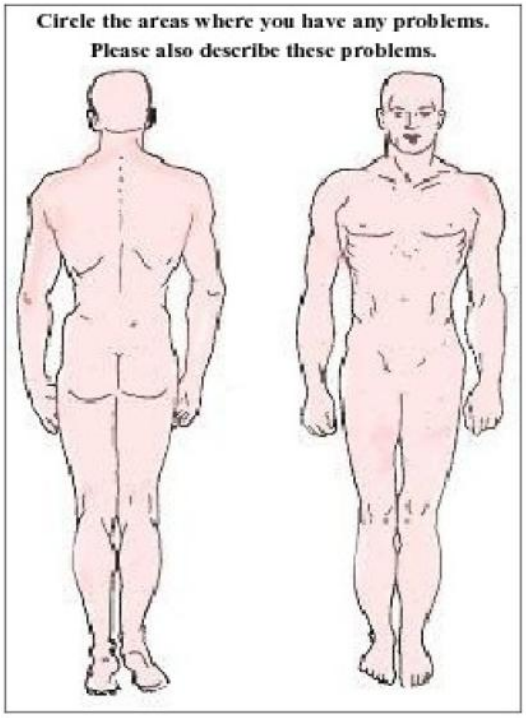
_____

_____

_____

_____

_____



Is there anything else regarding your health you wish to share with us?_____

_____

_____

Ocean LightForce® Chiropractic

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