Braile Chiropractic

Please print clearly and fill in completely

Print Name _____ **Email** _____

Street Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____ **Date of Birth** _____

Do you have insurance that you believe may cover part of your chiropractic care?

Please Check ✓ **Yes ❑ No ❑** **Name or type of insurance:** _____

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes❑ No❑ If Yes, explain conditions being treated for:

_____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History:

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? - Yes❑ No❑ Who? _____

Rate Your Overall Health

At Braile Chiropractic we are dedicated toward achieving your goal of total lasting health for each of our practice members. To better help you achieve this; we need to understand how you view your overall health. Based on a scale of 10% to 100%, please **circle** what you feel is your current level of health and wellness.

10%-------- 20% --------30%-------- 40% --------50%-------- 60% --------70%-------- 80% --------90% ------- 100%

Refferals

Our clinic is primarily referral based. We would like to know who we can thank for sending you to us. Please let us know who referred you, or where you hear about our clinic? _____

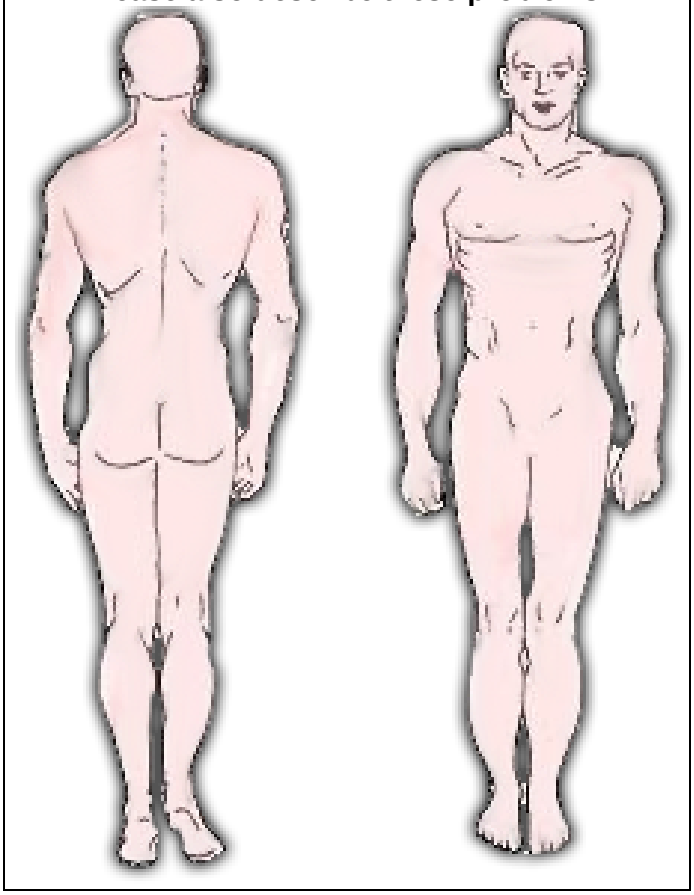
FEMALES: ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes ❑** **No ❑**

Please Fill in Below

If you currently or recently have suffered from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Please use the space below to fill in any additional health information you feel we may need for your care.

_____

_____

_____

_____

_____

_____

_____

_____

Your Signature Below Please

_____

Date: _____