Braile Chiropractic

Welcome Back - It's Good to See You Again !

Since it's been a while since we've seen you in our clinic, we need you to take just a few minutes to bring us up to date on how you're doing. Please complete this form to the best of your ability. It is very important that you use as much detail as possible. Please print.

Print Name_____ **Phone** _____

E-mail _____

If you have had a change of address since your last visit with us, please write it below.

_____

Current Health

Give current reason for seeking chiropractic care: _____

_____

_____

Describe any current health problems, compare these with any problems your may have had when you were previously under care with us:

_____

_____

Are you currently under the care of any other doctor? Yes❑ No❑
If Yes, please list the doctors you are seeing, the conditions being treated for.

_____

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%

_____

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:_____

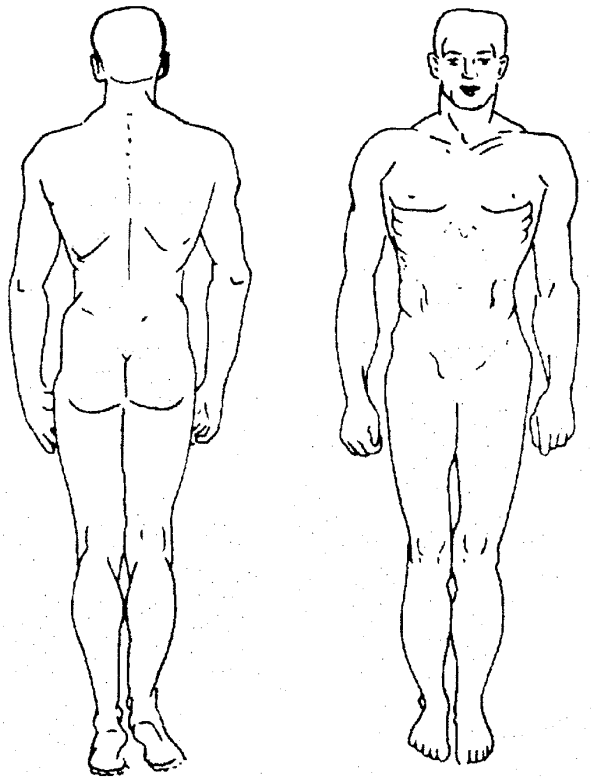
FEMALES:

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

If you now have the following, or if you suffer 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	❑	❑
Vision Changes	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Frequent colds	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

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



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____