Welcome to Spinal Corrective Center

Today's Date: ___/___/___ Home Ph. # ________________
Work Ph. #_________________
Name: ____
What you prefer to be called: __________________________________
Mailing (Street) Address:
____
City: ____________________________ State: _______ Zip Code: ________________
Email address (for patient newsletter)
____
Birth Date: ___/___/___ Age: ________ S.S. # _______________________________
How did you learn about our office?
____
Previous Chiropractic Care? ___ Yes ___ No
Approximate Last Visit Date: _____________________
Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Spouse's Name:
____
Names and Ages of Children:
____
Hobbies:
____
Patient's Employer/Business: __________________________
Occupation: _______________________
Recent work related injury? ___ Yes ___ No Auto Accident? ___ Yes ___ No

Please check reasons for pursuing chiropractic care:

___ *I'm continuing ongoing care from another chiropractor.*
___ *I'm Interested in wellness and natural health care.*
___ *I'm concerned about my health and I'm looking for answers.*
___ *I have a specific condition that concerns me.*
Explain condition or symptom:
____

____

____
___ *I want to improve my immune function.*
___ *I have no idea why I'm here. Please take the time to explain to me what you do.*

In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:

___ Dizziness or Fainting ___ Headache ___ Postural Imbalance ___ Arthritis ___ Asthma
___ Short Leg/Orthotics ___ Ear Infection ___ Intestinal Problems ___ Frequent Colds

___ Sinus Problems ___ High Blood Pressure ___ Bladder Problems ___ Kidney Problems
___ PMS ___ Menopausal Symptoms

Check the following conditions that YOU have or have had:
Circle conditions that are common to FAMILY MEMBERS:
__ AIDS __ Alcoholism __ Cancer __ Diabetes __ Epilepsy __ Hyper/Hypothyroidism
__ Heart Disease __ Lung Disease __ Multiple Sclerosis __ Scoliosis __ Stroke
__ Ulcers

List Prescription or Over The Counter Medications Now Taken:
____
____
____

Known Allergies:
____

The Stress Test

The following areas of stress can cause mis-aligned vertebra (subluxation).
Which of these stresses do you recognize?
Please circle when you experienced these stresses:
C (Child), T (Teenager), A (Adult)

Physical/Emotional/Chemical Stress:				Comments:
Birth Trauma	C			
Slips/Falls	C	T	A	
Car Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Sitting on a Wallet		T	A	
Sleeping on Stomach		T	A	
Extensive Computer Work		T	A	
Carrying Heavy Purse/Bookbag/Child		T	A	
Repetitive Lifting/Bending		T	A	
Driving for Many Hours		T	A	
Continuous Hours Sitting/Standing		T	A	
Children Stress			A	
Career Stress			A	
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/Second Hand Smoke	C	T	A	Amount: ________________

Poor Diet/Excessive Sugar	C	T	A	
Caffeine	C	T	A	Amount: ________________
Artificial Sweeteners	C	T	A	
Prescription Drugs	C	T	A	
Over-The Counter Drugs (ex. Tylenol, Motrin)	C	T	A	

Which do you feel are your primary stresses? ________________________________

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

____ (Signature)

___/___/___ (Date)