Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: (Home) _____ (Cell) _____ Cell Provider: _____

Email Address: _____ Date of Birth: _____ /_____ /_____

Height: _____ Weight: _____ Age: _____ Gender Pronoun: _____

For the purposes of creating a safe space in our office, in what other ways do you self-identify that you'd like to specifically and explicitly let us know? _____

_____

Occupation: _____ Employer's Name: _____

Single / Married / Widowed / Partnered – Name: _____

Number of Children: _____ Names & Ages: _____

_____

Who may we thank for referring you in? -- _____

PLEASE LIST YOUR HEALTH CONCERNS

Health Concerns: List Main Concern First	**Rate Severity** 1= Mild 10= Unbearable	**When did this episode start?**	**Did you have this condition before? When?**	**Did the problem begin with an injury?**	**Constant? Intermittent?**

Since these complaints/concerns started, are they:

_____ ABOUT THE SAME _____ GETTING BETTER _____ GETTING WORSE

What makes it worse? _____

What makes it better? _____

What are these concerns keeping you from doing? _____

_____

Have you seen any other doctors/ health providers for this condition?

_____ Chiropractor _____ Medical Doctor _____Other

If so, WHO & WHEN: _____

List SURGERIES (if any) and dates: _____

_____

List all MEDICATIONS/SUPPLEMENTS you are currently taking or have taken during this pregnancy:

_____

_____

Pregnancy & Fertility History:

Any fertility issues or treatments?	Yes	No	If yes, please explain:
Do you smoke?	Yes	No	If yes, how many per week?
Do you drink?	Yes	No	If yes, how many per week?
Do you exercise?	Yes	No	If yes, please explain:
Any illnesses during pregnancy?	Yes	No	If yes, please explain:
Any ultrasounds?	Yes	No	If yes, please explain:

Please explain any notable episodes of mental or physical stress during your pregnancy:

_____

_____

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

_____

_____

Childbirth care givers (please list):
OB/GYN _____
Midwife _____
Doula _____
Birth coach/educators_____
# of previous pregnancies_____ # of deliveries_____
Please describe any difference in numbers: _____

_____

Any complications in previous pregnancies or deliveries?

_____

_____

When was your last Auto Accident? _____

Have you ever been knocked unconscious?_____YES _____ NO

Fractured any bones? _____YES _____ NO – If YES, please describe: _____

Any other bodily trauma: _____

CIRCLE ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

DIZZINESS	ASTHMA	KIDNEY PROBLEMS	CHRONIC FATIGUE
HEADACHES	ULCERS	BLADDER PROBLEMS	LUPUS
VERTIGO	CHEST PAINS	IRRITABLE BLADDER	FYBROMYALGIA
EAR INFECTIONS	ARM NUMBNESS	SCIATICA	ADD / ADHD
ALLERGIES	ARM PAIN	LEG NUMBNESS	GERD
TMJ	HAND NUMBNESS	FEET NUMBNESS	ANXIETY
NECK PAIN	SHOULDER PAIN	LOW BACK PAIN	NERVOUSNESS
MIGRAINES	HEART DISORDERS	HIP PAIN	EPILEPSY
STIFFNESS IN NECK	MID BACK PAIN	LEG PAINS	DISC PROBLEMS
CHRONIC SINUS	STOMACH DISORDERS	KNEE PAIN	INFERTILITY
THROAT ISSUES	NAUSEA or REFLUX	LIVER DISEASE	OTHER
THYROID ISSUES	HIGH BLOOD PRESSURE	MENSTRUAL ISSUES	

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE - CANCER - HEART DISEASE - SPINAL SURGERY - SEIZURES - SPINAL FRACTURE - SCOLIOSIS – DIABETES

What are your expectations with care at The Source Chiropractic? _____

_____

_____ _____ _____

PRACTICE MEMBER NAME **SIGNATURE** **DATE**