980 S. EUCLID • ANAHEIM, CA 92802 • (714) 535-1404 • FAX (714) 535-1497

Please PRINT an answer to each question on this form. If the question does not apply to you, put an "N/A" in that blank.

1. Name (Full Name)				2. Date
3. Address	4. City		5. State	6. Zip
7. Home phone E-Mail / Work phone	8. Date of Birth	9. Age	10. Sex: M F	
11. ☐ Married ☐ Single / Other (Specify)	12. Ages of Children	13. Occupation		
14. Are You: ☐ Working ☐ On Medical leave ☐ Laid-Off ☐ Retired ☐ Other	15. Employer & Address			
16. Driver's License No.	17. Social Security No.	18. Name, Address & Phone of Emergency Contact:		
19. Insurance Co.	☐ Medicaid ☐ Medicare	☐ General Assistance ☐ Champus	☐ Auto Acc. ☐ Worker's Comp.	
20. Where or what is your main problem?	21. How did it start?			
22. How long has this been bothering you?	23. Are there other health problems? ☐ Yes ☐ No If Other, explain:			
24. Where did you hurt yourself? ☐ Home ☐ Work ☐ Car Accident ☐ Other If Other Explain:	25. Date of Injury	26. Is there an Attorney involved in this injury? ☐ Yes ☐ No If Yes, print Name, Address & Phone No.		
27. Have you had this or any similar problems before? ☐ Yes ☐ No If Yes, explain:				
28. Have you had treatment for this problem? ☐ Yes ☐ No If Yes, explain:				
29. Name of Dr. or hospital where treated				
30. Have you ever been to a Chiropractor before?	31. Date of most recent adjustment			
32. Length of time under care	33. What was the treatment for?			
34. Are you here for: ☐ Relief only ☐ Full correction of your problem	35. How were you referred to us?			

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36. List ALL previous auto accidents or other injuries:

MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

37. List ALL previous surgeries:

MONTH, YEAR	TYPE OF SURGERY	COMMENTS

38. List ANY medications you are presently taking

NAME OF DRUG	DOSES PER DAY	LENGTH OF TIME TAKING

39. Please carefully review the following list.

Mark the box with a "C" if you are currently bothered by any of the following symptoms.
Mark the box with a "P" if any of these symptoms have bothered you in the past.

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Sinus trouble
- ☐ Loss of smell
- ☐ Allergies
- ☐ Hayfever
- ☐ Asthma
- ☐ Loss of taste
- ☐ Tightness of throat
- ☐ Inflammation of throat
- ☐ Thyroid trouble
- ☐ Twitching of face
- ☐ Loss of memory
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Lights bother eyes
- ☐ Neck pain
- ☐ Muscle spasms in neck
- ☐ Grating in neck
- ☐ Tightness of shoulder muscles
- ☐ Pain in shoulders and arms
- ☐ Pins and needles in arms and hands
- ☐ Cold hands
- ☐ Chest pains
- ☐ Shortness of breath
- ☐ Mid-back pain
- ☐ Pins and needles in legs
- ☐ Heart attacks
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Stomach trouble
- ☐ Nerves and nervousness
- ☐ Inner tension
- ☐ Irritability
- ☐ Cold sweats
- ☐ Gall bladder trouble
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Low back pain
- ☐ Swollen ankles
- ☐ Cold feet
- ☐ Pain in legs and feet
- ☐ Numbness
- ☐ Constipation
- ☐ Kidney trouble
- ☐ Menstrual cramps and pain
- ☐ Menstrual irregularity
- ☐ Diabetes
- ☐ Cancer
- ☐ Sleeping problems
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Pinched nerves in back

Patient to SIGN name here: ______________________________

Patient to PRINT name here: ______________________________

Witnessed by: ______________________________