

Previous and Current Health Care

Include dates and doctors' names.

If not applicable, please write "none" or "N/A"

Family/primary care physician: _____

Please describe recent medical or other care:

Please describe previous chiropractic care:

Please describe any medications you take regularly
(prescription or over the counter):

Please describe any surgery you have had, including dental
and elective surgeries:

Please describe any injury you have had, including falls, car
accidents, etc:

Please list your family medical history (diabetes, cancer, high
blood pressure, stroke, heart attack, family diseases, etc.).
Indicate relationship (eg. parent, grandparent, sibling):

Please circle your current level of activity:

Regular Occasional None

Is your activity aerobic (raises your pulse for at least 20
minutes, 3 times/week)? Yes No N/A

Use of Smokeless Tobacco: ____/day

Use of Alcohol: ____ drinks/day

Use of Caffeine : ____ drinks/day

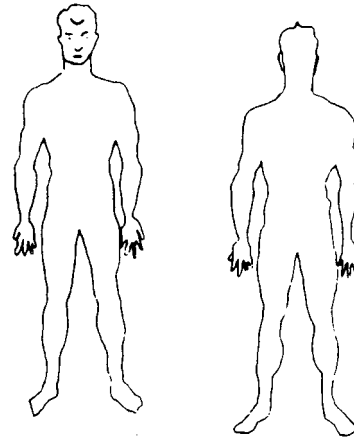
Do you currently smoke? Yes No
If yes, how many packs per day ?
 <1 1 2 3>
For how many years ? _____

Have you quit smoking? Yes No
If yes, when did you quit ? _____
How many packs per day did you smoke ?
 <1 1 2 3>
For how many years ? _____

Have you ever been a victim of abuse? Yes No
(This question allows us to be sensitive to your
needs, and is intended to assist you in seeking
appropriate resources if you have not yet done so.)

Current Areas of Concern

Please mark areas of concern on these diagrams:



*Please list below the main complaints you have, in
order of importance.*

Describe pain: what & where How long?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

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Performance Chiropractic
New Patient Clinical

Patient Signature _____ Print Name _____ Today's Date _____
If patient is under 18 years old, parent or guardian must sign : _____