

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>

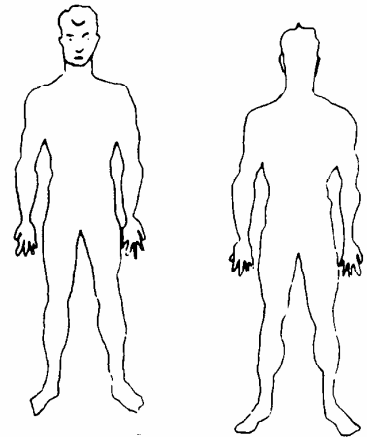
For how many years ? _____

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. _____

Performance Chiropractic
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New Patient Clinical
Updated: 10.14.2009

Patient Signature _____ Print Name _____ Today's Date _____

If patient is under 18 years old, parent or guardian must sign : _____