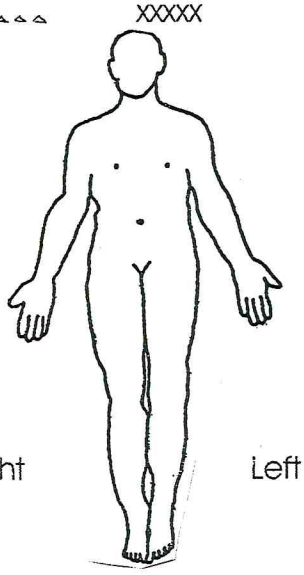
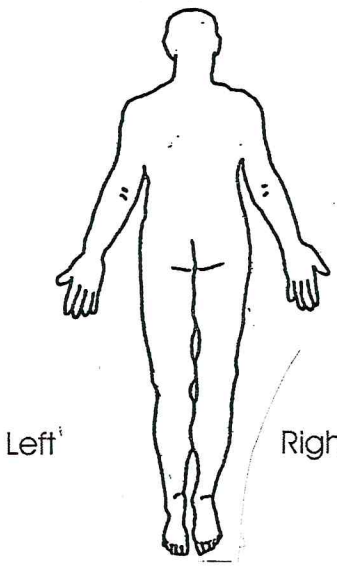
Add Life Chiropractic & Wellness Center

Patient Name _____ M/F ___ DOB ___/___/___ Age _____
Last, First MI
Street Address _____ Apt# ___ City _____ St ___ Zip _____
Mailing Address _____ Apt# ___ City _____ St ___ Zip _____
Home# _____ Work# _____ Cell# _____ Email _____
SS# _____ Employer _____ Occupation _____
Single _____ Married _____Separated _____ Divorced _____ Widowed _____ # of Children _____
Spouse's Name _____ Employer _____
In the event of an emergency, who should we contact? Name _____
Relationship _____ 1st contact# _____ 2nd contact# _____ 3rd contact#_____
Who may we thank for referring you to our office? Name _____
Patient ____ Friend ____ Relative ____ Yellow Pages ____ Location ____ Insurance ____ Other _____
What is your primary concern/complaint? _____
Is condition due to: Auto Accident _____ Work Injury _____ Other Accident _____ Unknown _____
If other please describe _____
Date of: Accident/Injury ____/____/____ Illness ____/____/____ Gradual Onset ____/____/____
Are your symptoms: Improving ____ Getting worse ____ About the same _____ Come and go _____
Circle any activities which aggravate your condition: Standing Walking Lying Sitting
Bending Lifting Getting up Twisting Breathing Eating Stairs Coughing Sneezing
Are symptoms worse in the: Morning Evening? Does it wake or bother you during the night? Yes No
Does it increase with activity? Yes No Does it decrease with rest? Yes No Have you had these
symptoms before? Yes No If yes, please give dates _____
Other Doctor(s) seen for this condition: Chiropractor ____ M.D. ____ Osteopath ____ Orthopedic ____
Neurologist ____ Acupuncturist ____ Dentist ____ Podiatrist ____ Other_____
Dr's Name _____ Date last consulted ____/____/____ Diagnosis_____
Tests Performed: MRI ___ CAT Scan ___ Urinalysis ___ Blood ___ Other _____
Length of time under care: From ____/____/____ to ____/____/____
Are you pregnant? Yes No Unsure Date of last menstruation ____/____/____
Please indicate on the figures below where, and what kind of pain or problem you are experiencing.
Please use the symbols below for each problem.

Aching ^^^^^ Burning xxxxx Numbness - - - - - Pins and Needles ooooo Stabbing /////





Please circle all that apply:

Headaches

Muscle Spasms

Dizziness

Loss of Sleep

Ear Noises

List other: _____