552 S. Washington St. Suite 120
Naperville, IL 60540
(630) 995-3189

Patient History

Name ______________________________ SSN ____________________ Date of Birth ___________
Address ____________________________City/State _____________________ Zip ______________
Home Phone _______________________ Cell Phone __________________ Email: _____________
Do you wish to get text/email appointment reminders? YES NO

Occupation ______________________ Employer ___________________
Marital Status S M D W Spouse's Name ______________
Number of Children ______ Children's Ages ______________________
Have you ever received chiropractic care? YES NO If yes, approximate date of last visit? ________

Primary reason for visit:

Health History
Surgeries or Hospitalizations? YES NO If yes, please explain: ______________________________
____
____

Work Injury? YES NO If yes, please explain: ____
____
____

Auto Injury? YES NO If yes, please explain: ____
____

Sports Injuries or Other? YES NO If yes, please explain: ____________________________________
____

Current Health Habits

Do you smoke? YES NO Packs per day ____________ Glasses of water per day: _______________
Current medications: ____
____
Current Supplements/Vitamins: ____
____
Do you exercise regularly? YES NO Light ____ Moderate ____ Heavy ____
Do you experience daily stress? Little Stress 1 2 3 4 5 6 7 8 9 10 Very Stressed
Hours of sleep per night? ____ Are you currently pregnant? YES NO How many weeks? _____

Symptoms and Present State of Health

Date pain or problem began ____
Pains are: Sharp Dull/Ache Constant Tingling Intermittent Other ____________
Does the pain shoot/radiate/travel in your body? Where? ______________________
Are you experiencing numbness or weakness anywhere in your body? _______________
Since the pain began, is the pain: Same Better Worse
Which activities aggravate your symptoms? ________________________________
Which activities lessen your symptoms? __________________________________
Is your condition worse during certain times of the day? ______________________
This condition interfering with: Work Sleep Routine Self Care Concentration Other ___
Rate your pain 0-10 (10 worst pain imaginable): ____/10
Other providers seen for this condition: __________________________________

Please mark any of the following conditions that you have now or have experienced:

	Allergies		Fertility Challenges		Muscle Weakness		Varicose Veins
	Anxiety		Food Sensitivities		Neck Pain		Weight Challenges
	Asthma		Frequent Illness		Numbness/Tingling		
	Back Pain		Headaches/Migraines		Painful Joints		Other:
	Bleeding Disorder		High/Low BP		Poor Circulation		
	Cancer		High Cholesterol		Pregnancy		
	Chronic Constipation		Hip Pain		Reflux/GERD		
	Depression		Hot Flashes		Ringing in Ears		
	Diabetes		Incontinence		Scoliosis		
	Digestive Complaints		Jaw Pain		Sinus Pain		
	Dizziness/Vertigo		Kidney Stones		Sleep Challenges		
	Ear Infections		Low Back Pain		Stress		
	Fatigue-Chronic		Menstrual Problems		Stroke		

Family History of Major Illness: ______________________________________
____

Any additional health concerns you wish to discuss: __________________________
____
____

I hereby certify that the statements and answers given above are accurate to the best of my knowledge and understand that it is my responsibility to inform the provider of any changes to my health. I agree to allow the provider to examine me for further evaluation and treatment.

Patient Signature: ____________________________ Date: _______________