FOX CHIROPRACTIC CENTER
(630) 232-6321

Patient Name: ______________________ Birthdate:__________ Sex: M/F Today's date :__________

Address: ____________________________City:____________________ State______Zip________

Home #: ______________Email Address: ____________________ Cell #: ________________

Employer: _______________ Occupation: ______________ ☐ Full Time ☐ Part Time ☐ Retired

Work #:_______________

Social Security #:__________________ Referred By:_______________

Person to contact in case of emergency: ___________________ Relationship: _________________

Home Phone: ___________________ Cell Phone: ___________________

Regular Medical Doctor: __________________________

Billing Method: (Circle One)

Major Medical Insurance　　*Personal Injury*　　*Workers Compensation*　　*Cash*

Family History:	Back	Heart	Stroke	Cancer	Diabetes	High BP	Arthritis	Thyroid	Osteoporosis	High Cholesterol	Good Health	Unknown	Other
Mother:													
Father:													
No. of Sisters ___													
No. of Brothers ___													
No. of Children ___													

Social History:	Daily	3X/Week	2X/Week	1X/Week	2X/Month	1X/Month	Never
Standing:							
Sit at a Desk:							
Work on a Computer:							
Work on a Phone:							
Moderate/Heavy Labor:							
Stay at Home:							
Deliver Packages:							
Tobacco/Smoke:							
Alcoholic Beverages:							
Caffiene:							
Exercise:							

Surgical History: ________________________ Date Performed: ________________
________________________ Date Performed: ________________
________________________ Date Performed: ________________

Smoking Status: (Please Circle) *Daily* *Occasionally* *Never* *Former*

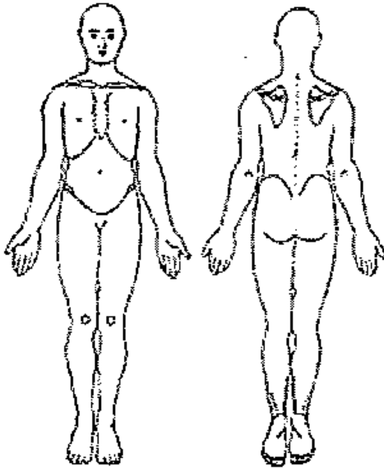
Height: ________ Weight: __________BP: _________HR: __________
Allergies: ____
Medications & Supplements: ______________________________
____

Health History: Please check all that apply to you:

__ADHD
__Alcohol/Drug Addiction
__Allergies
__Anemia
__Aortic aneurysm
__Arrhythmia
__Arthritis
__Asthma
__Back Pain/Joint Pain
__Birth Control Pills
__Bleeding Disorder
__Blood Clots
__Blood Transfusion
__Blurred Vision
__Bowel Problems
__Broken Bones
__Cancer
__Carpal Tunnel
__Cataracts
__Chickenpox
__Colitis
__Pneumonia
__Polio
__Collagen Vascular Disease
__Constipation
__Depression/Anxiety
__Diabetes
__Digestive Disorders
__Dizziness/Fainting
__Eating Disorder
__Emphysema
__Epilepsy/Seizures
__Fatigue
__Female Health Challenges
__Fibromyalgia
__Gallbladder Disease
__Glaucoma
__Gluten Intolerance
__Gout
__Headaches/Migraines
__Hearing Loss
__Heart disease/ Attacks
__Heart Murmur
__Hemorrhoids
__Hepatitis
__High blood pressure
__High Cholesterol
__HIV/AIDS
__Hysterectomy
__ Kidney Infections/ Stones
__Liver Disease/ Problems
__Lung Disease
__Menstrual Cramps
__Mental Disorder
__Neck pain
__Nervousness
__Night Sweats
__Osteoporosis
__Paralysis
__Pregnancy, __ # of births
__Prostate problems
__Rheumatic Fever
__Sexual Dysfunction
__Sickle Cell
__Sinus Trouble
__Stress/Tension
__Stroke
__Suicidal Tendencies
__Thyroid problem
__Tuberculosis
__Tobacco Use : __yrs
__Tumor/growth
__Ulcer/Reflux
__ Urine Discoloration
__ Vertigo

Are you currently pregnant? (Please Circle): *Yes* or *No*

Please Mark with an "X" on the picture below where your pain/discomfort is currently



Type of Pain:

___Aching ___Burning ___Sharp ___Dull ___Radiating
___Stiff ___Stabbing ___Sore ___Tight ___Sharp
___Numbness ___Cramping ___Throbbing ___ Pounding
___Constricting ___Shooting ___Tingling

Is your pain/discomfort primarily on one side?

___ Right
___ Left
___ Bilateral

On a scale of 1-10, 10 being most intense, how would you rate your pain?

___/10

DESCRIBE YOUR CURRENT PROBLEM:

____

____

DATE PROBLEM BEGAN:_______________________

HOW PROBLEM BEGAN: (please explain)

☐ Gradually ☐ Sudden ☐ Overtime ☐ Other

____

____

Have you seen anyone else for this condition? If yes, describe:

____

____

Have you had spinal X-Rays, MRI, CT Scan?__________________ Approximate date:__________________

How often are your symptoms present:

_____0-25% _____26-50% _____51-75% _____76-100%

Can you perform your daily activities? If No, describe:

____

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