Nebraska City Chiropractic

Basic Information

Date ___/___/_____
Full Name _____
Current Address _____
City, State, Zip _____
Home Phone (____)_____
Cell Phone (____)_____
Work Phone (____)_____
S.S. # _____
Birthday ____/____/_____
Email _____@_____
(Check One) Male ○ Female
Marital Status

Employer_____
Occupation_____
Name of Insurance:
Primary_____
Policy #_____
Secondary_____
Policy # _____
Relation to Insured_____
Insured DOB ____/____/_____
Primary Care Physician's Name
_____
How did you hear about us?

Current Physical Health

What main reason brings you in to us today? _____
_____
Do you have: ○ pain ○ numbness ○ tingling ○ aches
Is it: ○ sharp ○ dull ○ throbbing ○ burning ○ stiff ○ tight
Aggravates Condition_____
Improves Condition_____
On a Scale of 1-10 (1 least, 10 worst) please rate the severity of your symptoms_____
How are these health conditions affecting your life? _____
_____

Goals and Expectations

If you could change one thing about your physical health what would it be?
_____
And your emotional health?_____
And your nutritional (chemical) health?_____
What are your expectations of us?_____
What are your wellness goals that you would like to accomplish?_____
_____

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Health History

List all major injuries and/or surgeries you have ever had with approximate dates.

_____

_____

Check any of the following conditions that apply to you:

- ◯ Alcohol/Drug Abuse
- ◯ Anemia
- ◯ Arthritis
- ◯ Artificial bones/joints
- ◯ Artificial valves
- ◯ Asthma
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Chronic bad breath
- ◯ Congenital heart defect
- ◯ Depression
- ◯ Diabetes
- ◯ Difficulty breathing
- ◯ Emphysema
- ◯ Fainting/seizures
- ◯ Frequent neck/back pain
- ◯ Glaucoma
- ◯ Heart Attack
- ◯ Heart murmur
- ◯ Hepatitis
- ◯ High blood pressure
- ◯ HIV+/AIDS
- ◯ Low blood pressure
- ◯ Lyme Disease
- ◯ Pacemaker
- ◯ Psychiatric disorder
- ◯ Headaches
- ◯ Shingles
- ◯ Sinus problems
- ◯ Skin condition
- ◯ Stroke
- ◯ Ulcers/Colitis
- ◯ Venereal Disease
- ◯ Other:_____

Please list any major health conditions your family members have experienced.

Lifestyle

Check those that apply to you.

Exercise
- ◯ none
- ◯ moderate
- ◯ daily
- ◯ heavy

Work Activities
- ◯ mostly sitting
- ◯ mostly standing
- ◯ light labor
- ◯ heavy labor

Stress Level
- ◯ none
- ◯ low
- ◯ moderate
- ◯ high

Values

Please list these in order of importance 1-7 (1 being most important)

___Financial ___Family
___ Social ___Physical
___Mental ___Spiritual
___Work

Family	Name	Age
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

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Chemical (Nutritional) Health

How many bowel movements do you have per day/week? _____

Check the answer that best describes the following:

Typical color of your urine:
- ○ Light yellow
- ○ Yellow
- ○ Orange
- ○ Red
- ○ Brown
- ○ Green

Typical clarity of your urine:
- ○ Clear
- ○ Slightly Cloudy
- ○ Very Cloudy
- ○ Mucous
- ○ Bloody

Date of last dental cleaning _____
Number of fillings_____
Type of fillings _____

Emotional Health

Have you been diagnosed with any mental disorders? List them with the date of diagnosis. _____
Do you frequently experience emotional highs and lows? Describe these emotions.
_____

For the following check yes or no.
I love myself. ○ yes ○ no
I am satisfied with my life. ○ yes ○ no
I enjoy my job. ○ yes ○ no
I tend to have great relationships. ○ yes ○ no

I hereby declare that all information provided is true and current to the best of my knowledge.

Signature _____ Date _____