Welcome

Queen Creek Chiropractic

20231 E Ocotillo Rd # 1

Queen Creek, AZ 85142

(480) 987-0585

**Patient Information**

Describe the Reason(s) for your Visit Today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When Did the Problem Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

MI

First

Last

Address:

Phone #:

Work Phone

Home Phone

Cell Phone

Age: \_\_\_\_\_ M\_\_ F\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Marital: M S W D # of Children: \_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do Your Symptoms Interfere with your Work or Normal Activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your Symptoms: (circle one) Getting Better Staying the Same Getting the Same

How often do you Experience Symptoms? (circle one) Constantly Frequently Occasionally Intermittently

Describe your Symptoms (circle one): Sharp Dull Ache Numbing Burning Tingling Shooting

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**Chiropractic Adjustment**

Have you maintained your Spine with Adjustments in the Last Year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your Last Adjustment? \_\_\_\_\_\_\_\_\_\_\_\_ Previous Chiropractor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had recent X-Rays, MRI’s, or CT’s of your Neck or Back?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear? Heal Lifts:\_\_\_ Arch Support:\_\_\_ Orthotics:\_\_\_ Magnets:\_\_\_ High Heels Regularly:\_\_\_

Do you have Body Piercings? Yes\_\_\_ No\_\_\_ Do you have Tattoos? Yes\_\_\_ No\_\_\_

**Accident Information**

Is this visit due to an accident? Yes \_\_ No \_\_ If Yes, what type? Auto \_\_ Work \_\_ Other \_\_\_\_\_\_

Has it been reported? Yes \_\_ No\_\_ N/A \_\_ If Yes, to whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Injuries**

Any Injuries That Did Not Heal Well? Please List Including Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Surgeries or Hospitalizations you have had including Month & Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitamins, Minerals, and Herbal Supplements:**

Currently Taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**

[ ] Pain Medication [ ] Tranquilizers [ ] Anti-Depressants [ ] Steroids [ ] Birth Control

Other Medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Unhealthy Habits:**

Smoking Tobacco [Y] [N] If Yes, # per Day? \_\_\_\_ # of Years \_\_\_\_\_ Chewing Tobacco [Y] [N]

Alcohol: # per Week \_\_\_\_\_ Sugar: Serving per Day \_\_\_\_\_ Caffeine: Type & # per Day \_\_\_\_\_\_\_\_\_\_\_\_

Overeating & Eating Poorly: How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthy Habits:**

Strength Training Exercises: Type & Times per Week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flexibility Exercises: Times per Week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Servings of Raw Fruit & Vegetables: # per Day \_\_\_\_\_\_\_\_\_\_\_\_\_ Water: # per Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep: Are you Getting at Least 7 Quality Hours per Night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OB/GYN: Pregnant? \_\_\_\_\_\_\_\_\_\_ # of Pregnancies \_\_\_\_\_\_\_\_\_ # of Children \_\_\_\_\_\_\_\_\_\_

Date of Last Pelvic Exam? \_\_\_\_\_\_\_\_\_

**Health History:**

Please check to indicate if you have Ever Had any of the Following:

* Diabetes
* Blood Clots
* Varicose Veins
* Emphysema
* Ulcers
* Heartburn
* Weight Loss
* Weight Gain
* Fibromyalgia
* Gout
* Diarrhea Regularly
* Constipation
* Psoriasis
* Spit Up Blood
* AIDS
* Asthma
* Arthritis
* Neuralgia
* Dizziness
* Disc Problems
* Bruise Easily
* Valley Fever
* Back Pain
* Neck Pain
* Nausea
* Polio
* Sciatica
* Liver Disease
* Cancer
* Heart Disease
* Stroke
* High Blood Pressure
* Menstrual Problems
* Kidney Stones
* Bronchitis
* Tuberculosis
* Lung Disease
* Digestive Problems
* Emotional Disorders
* Hypothyroid
* Hyperthyroid
* Pinched Nerve
* Pacemaker
* Headaches
* Allergies
* Hot Flashes
* Eye Pain
* Fatigue
* Muscle Aches
* Loss of Smell
* Loss of Taste
* Loss of Balance
* Loss of Memory
* Insomnia
* Hearing Problems
* Endometriosis

Please List any Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

List all Major Diseases Such as Cancer, Diabetes, Heart Problems, Bone/Joint Diseases and your Relationship to the Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian (if a Minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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