Today's date___/___/___ Name _____

Address_____City_____State_____Zip_____

Phone # ( ) _____ Email: _____

Birth Date___/___/_____ Age _____ Male _____ Female _____ # of children _____

Occupation: _____ Women: Are you pregnant? Y N

**Chief Complaint** (why are you here today):

_____

_____

When did this condition begin? _____ Severity: Mild / Moderate / Severe

Have you ever seen a chiropractor before? Y / N If so, when was your last adjustment?
_____

On a scale from 1-10 with 10 being the highest, what is your level of commitment to correcting the problem? _____

I would like to know more about: (Please Circle)

Pain Management Health Coaching Nutritional Counseling

Spinal Decompression Acupuncture Chiropractic Care for Children

Would you like to lose 6 – 16 pounds in 8 days? YES NO

Do you often feel tired? YES NO Do you need more energy? YES NO

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**I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge.**

_____ _____

**Signature** **Date**