TREATING DOCTOR:_____

Date: _____

PERSONAL HISTORY

Name: _____ E-mail Address:_____

Address: _____ City:_____ State: _____ Zip Code:_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Birth Date: ___/___/___ Age: _____ Sex: □ M or □ F Social Security Number: _____

Business Employer: _____ Type of Work: _____

Marital Status (Circle One): Married Single Widowed Divorced Separated Spouse's Name:_____

Name and Ages of Children: _____ Name of Health Insurance: _____

Is Policy under Spouse? □ Yes □ No If yes, Spouse Birth Date:___/___/___ Spouse Employer: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Referred To This Office By: □Friend/Relative _____ □Yellow Pages □Insurance Comp. □Other_____

CURRENT HEALTH CONDITION

Reason For Visit: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? □Yes □No

Rate The Pain You Are Experiencing (0 no pain/10 most severe):_____ Is Pain Affecting Daily Activities? □Yes □No

Is The Pain: □ Constant □Comes and Goes □Other_____ Pain worse in : □AM □PM □Other_____

What Makes the Pain Worse? □Sitting □Bending □Standing □Lying Down □Walking □Weather □Other_____

What Makes the Pain Less? □Ice □Heat □Rest □Stretch □Over the Counter Med □Prescription Med □Other_____

Is Condition: □Job Related □Auto Accident □Home Injury □Fall □Other: _____

Date of Accident: _____ Have You Reported Your Accident To Your Employer: □Yes □No

Current Medications/Vitamins/Herbs: _____

Other Doctors Seen For This Condition: □Yes □No If yes, please list: _____

PAST HEALTH HISTORY

Previous Chiropractic Care: □None □ Doctor's Name & Approximate Date of Last Visit: _____

Have You Had Any X-rays Taken In The Past Two Years? □Yes □No If yes, where_____

Past Injuries Can Affect Current Health (Please Check and Describe)

Surgery/Operations: □Appendix □Tonsils □Gall Bladder □Hernia □Neck/Back Surgery □C-Section □Other: _____

Describe The Checked Above: _____

Accidents/Injuries: □Auto Accident □Sports Injury □Work Related □Fall on Ice □Fall from Height □Concussion/Unconscious
□Head Injury □Broken Bones □Dislocations □Other_____

Describe the Checked Above:_____

FAMILY HEALTH HISTORY

Please Check and Indicate Family Members That Have/Had The Condition (include: mother, father, sibling, spouse, child, grandparent)

□Heart Disease _____ □Stroke _____

□Cancer _____ □Diabetes _____

□Lung Disease _____ □High Blood Pressure_____

□Other_____

CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:

☐ Pneumonia	☐ Anemia	☐ Chicken Pox	☐ Kidney Disease	☐ Epilepsy
☐ Rheumatic Fever	☐ Measles	☐ Diabetes	☐ Thyroid	☐ Mental Disorders
☐ Polio	☐ Mumps	☐ Cancer	☐ Pleurisy	☐ Migraine Headaches
☐ Tuberculosis	☐ Small Pox	☐ Heart Disease	☐ Arthritis	☐ High Blood Pressure
☐ Whooping Cough	☐ AIDS/HIV	☐ Liver Disease	☐ High Cholesterol	☐ Osteoporosis

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GASTRO-INTESTINAL
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heart burn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO- URINARY
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problem/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulties
- ☐ Stuffed Nose

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headache

MALES ONLY:
- ☐ Prostate Problem
- ☐ Sexual Dysfunction

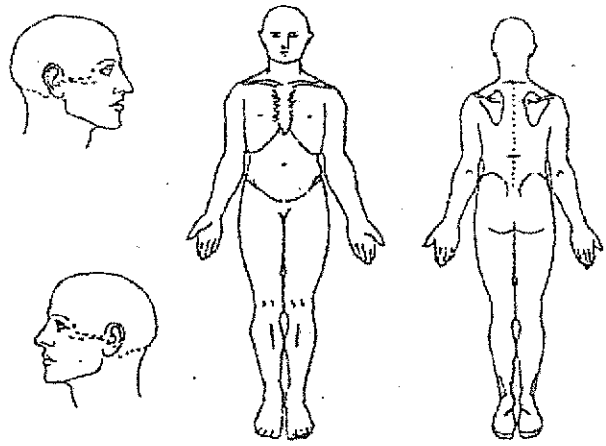
FEMALES ONLY:
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Menstrual Cramps/Irregularities

When was your last period? _____

Are you pregnant? ☐ Yes ☐ No ☐ Unsure

If yes, due date: _____

Please MARK on the diagram below the area(s) of your discomfort



QUALITY OF PAIN (check all that apply)

☐ Sharp ☐ Dull ☐ Achy ☐ Tight

☐ Numb/Tingle ☐ Burning ☐ Shooting

HABITS
- ☐ Smoking _____ packs/day
- ☐ Alcohol _____ drinks/week
- ☐ Coffee/Caffeine _____ cups/day
- ☐ Water _____ cups/day
- ☐ High Stress—reason _____

SLEEP

Hours per night _____

Position: ☐Back ☐Side ☐Stomach ☐All

Number of Pillows _____

EXERCISE

☐ None ☐ _____ days/week

WORK ACTIVITY

Years at Current Job _____

☐ Sitting ☐ Standing

☐ Light Labor ☐ Heavy Labor

INFORMED CONSENT: Certain types of cervical manipulations carry a slight risk of stroke. These are known as rotary breaks. This type of adjustment, using considerable rotation, is **NOT** used in this office.

NOTE: You (the patient) are liable for any charges deemed not medically necessary and/or for any balances not paid by your insurance company.

Patient Signature: _____ **Date:** _____

Jonker Chiropractic, SC 1620 London Rd Duluth, MN 55812 Phone: (218)269-1124