O'Malley Family Chiropractic

Please Print Clearly and fill In completely.

Print Name _____ **Email** _____

Street Address_____ **Phone** _____

City _____ **State** _____ **Zip** _____ **Date of Birth** _____

Age_____ ***Please Check*** ✓ Sex: Male❑ Female❑ Right handed❑ Left handed❑

Health History:

Give reason for seeking chiropractic care: _____

_____

Describe any health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes❑ No❑
If Yes, the conditions being treated for:

_____

List any current Medications:_____

List any past surgeries & dates: _____

List any past accidents & dates:_____

List any x-rays you've had in the past 2 years: _____

Personal & Work History:

Please Check ✓ Married❑ Single❑ # of children _____

Your Occupation:_____ Work Duties _____

Work Address:_____Cell Phone:_____

Emergency Contact:_____Emergency contact's phone:_____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care_____

Date of last chiropractic x-rays _____ How long were you under care? _____

Authorization to contact you and/or leave messages:

_____Please initial if we may contact you at home for appointment reminders and about account information.

_____Please initial if we may leave messages regarding your appointments on your answering machine or with your spouse/partner. Name of spouse/partner_____

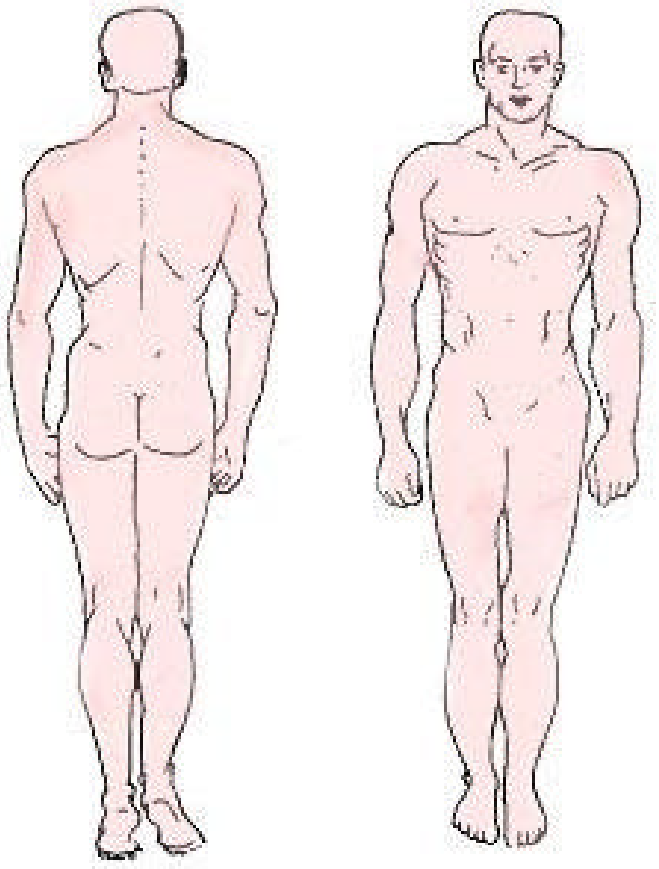
Where did you hear about our office,
or who referred you? _____

FEMALES: ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes❑** **No❑**

Please Fill in Below **If you have had the following, or if you suffer from the following, *Please Check* ✓**

Condition, Symptom Or Problem	Currently	In The Past
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness in hands or arms	❑	❑
Numbness in leg or feet	❑	❑
Dizziness	❑	❑
Allergies	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
High or	❑	❑
Low blood pressure	❑	❑
Cough	❑	❑
Chest pain	❑	❑
Menstrual cramps	❑	❑
Weight changes	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Cold hands or feet	❑	❑
Digestive problems	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Indicate the severity of your pain:

0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Please circle the quality of pain:

Aching	**Burning**	**Soreness**
Stiffness	**Numbness**	**Tingling**
Throbbing	**Pins & Needles**	**Stabbing**

Additional information:

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____