# Graycar Non-Force Chiropractic

Name _____ Date_____ Phone (home) _____

Phone (cell) _____ (work) _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Referred by _____ Social Security # _____-____-_____

Occupation_____ Employer _____

Marital Status S M D W Spouses Name _____

Number of Children_____ Ages _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit

Please describe,_____

Are you in pain? Yes No Please rate you pain on the following scale:

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: Work Sports/ Play Auto Accident Routine/ Household activity

When did your condition/ accident occur? ___/___/___ Where did your injury occur? _____

Please explain what happened:_____

Is your condition getting worse? Yes No Constant Comes and goes

Is your condition interfering with your: Work Sleep Daily routine

What lessens your condition?_____

What aggravates your condition? _____

Have you had previous chiropractic care? Y N When was your last treatment? _____

Have you had previous massage? Y N When was your last treatment? _____

Please list any other body work you have had _____

Has this or something similar happened in the past? Yes No

---

**Using the body charts below, please circle all affected areas.**

Please list any medications you are taking, including supplements or vitamins_____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

| | | |
|---|---|---|
| Y N Heart Attack/ Stroke | Y N Heart Surgery/ Pacemaker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves |
| Y N Alcohol/ Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N Anemia/ Diabetes | Y N Shingles | Y N Cancer |
| Y N Frequent Neck Pain | Y N Glaucoma | Y N Kidney Problems |
| Y N High/ Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever |
| Y N Severe/ Frequent Headaches | Y N Tuberculosis | Y N Ulcers/ Colitis |
| Y N Fainting/ seizures/ epilepsy | Y N Sinus Problems | Y N Emphysema/ Asthma |
| Y N Arthritis | Y N Difficulty Breathing | Y N Chemotherapy |
| Y N Lower Back Problems | Y N Headaches | Y N Artificial Bones/ Joints |

_____

Please list any surgeries with dates and/ or other serious medical condition(s) not listed above:

_____

List any past serious accidents with dates:

_____

Please list anything that you may be allergic to:

_____

Family Health History:

_____

Do you exercise? Yes _____ hours per week No

Do you smoke? No Yes How much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since ___/___/___

For women: Are you taking birth control? Yes No Are you pregnant? Yes No If so, how many weeks? ____ Are you nursing? Yes No

Signature_____ Date _____/_____/_____

Adult Patient Parent or Guardian Spouse