WELCOME TO YEN CHIROPRACTIC

Patient Information

Today's Date: _____
First Name: _____
Last Name: _____
Name preferred to be called:
_____
Address: _____
City: _____
State: _____ Zip Code: _____
Home Phone: _(____)_____
Cell Phone: _(____)_____
Date of Birth: _____Age: _____
Sex: □ Female □ Male
E-mail: _____
Occupation: _____
Employer/Business: _____
How did you hear about us?
□Internet □Mailer □Sign/Location
□Referred by _____
□Other: _____

Medical History

Injuries/ Surgeries you've had, and when:
Falls: _____
Head Injuries: _____
Broken Bones: _____
Dislocations: _____
Other: _____

Medical History

Family History:
Mother: □Back □Heart □Stroke □Cancer
□Diabetes □ High Blood Pressure
Father: □Back □Heart □Stroke □Cancer
□Diabetes □ High Blood Pressure
No. of Sisters: ____ No. of Brothers: ____
□Back □Heart □Stroke □Cancer
□Diabetes □ High Blood Pressure

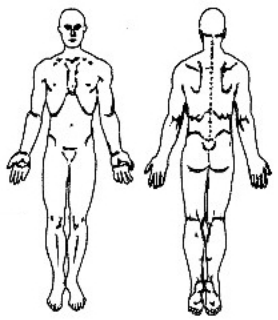
Your own condition checklist:

□ Alcohol/ Drug Addiction	□High BP
□ Anemia	□ High Cholesterol
□ Arthritis	□ Joint/Back Pain
□ Asthma	□ Kidney Disease
□ Bleeding Disorder	□Liver Disease
□ Bowel Problems	□ Lung Disease
□ Broken Bones	□ Mental Disorder
□ Cancer	□ Osteoporosis
□ Cataracts	□ Pneumonia
□ Chicken Pox	□Polio
□ Diabetes	□ Prostate Problems
□ Emphysema	□ Rheumatic Fever
□ Epilepsy	□ STD's
□ Glaucoma	□ Stroke
□ Gout	□ Suicidal Tendencies
□ Headaches	□ Thyroid Disease
□ Heart Disease/ Attacks	□ Tuberculosis
□ Hepatitis	□ Ulcers
□ Other:_____	□ Other: _____

Patient Condition

Reason for Visit: _____
When did symptoms appear_____
Is this condition getting progressively worse?
□ Yes □ No □ Unknown
Rate the severity of your pain from 1(least pain) to 10 (severe pain) _____
How often do you have pain? _____
Is it constant or does it come and go? _____
Type of Pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Movements painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying down

Mark an X on the picture where you continue to have pain, numbness or tingling.



Medication(s) - List them below and provide reason(s) for taking):
_____
_____
_____

See next page