Tompkins Family Chiropractic

Please Print Clearly and fill In completely.

Print Name _____ **Email** _____

Street Address _____ **Date of Birth** _____

City _____ **State** _____ **Zip** _____

Phone (Home)_____ **Phone (Cell)** _____

Please Check ✓ Sex: Male❑ Female❑ / Right handed❑ Left handed❑ / Married❑ Single❑ Other❑

Health History:

Give reason for seeking chiropractic care: _____

_____

_____

Is this condition getting progressively worse? Yes / No / Unknown

Is this condition due to an accident? Yes / No

Type of accident? Auto / Work / Home / Other

Type of pain: ___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting

___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other.

Please rate your condition on the scale below: 0 = no pain and 10 = severe pain

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

How often do you have this pain? _____

When is the pain at its worst? _____

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 / Imaging you've had in the past 2 years: _____

Personal & Family History:

Your Occupation: _____ Employer: _____

Work Duties _____ _____

Activities / Sports: _____

Spouse's health status_____

Children's ages and health status:_____

In case of emergency:

Name_____ Relationship: _____ Phone #: _____

Insurance Information:

Name of Insured: _____ Relationship: _____ DOB: _____

Insurance Company: _____ Phone #: _____

Policy / ID #: _____ Group #: _____

Type of policy: HMO / PPO / EPO / POS / other

Do you have more than one policy? Yes / No

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? _____

Are other family members under chiropractic care? - Yes❑ No❑ Who? _____

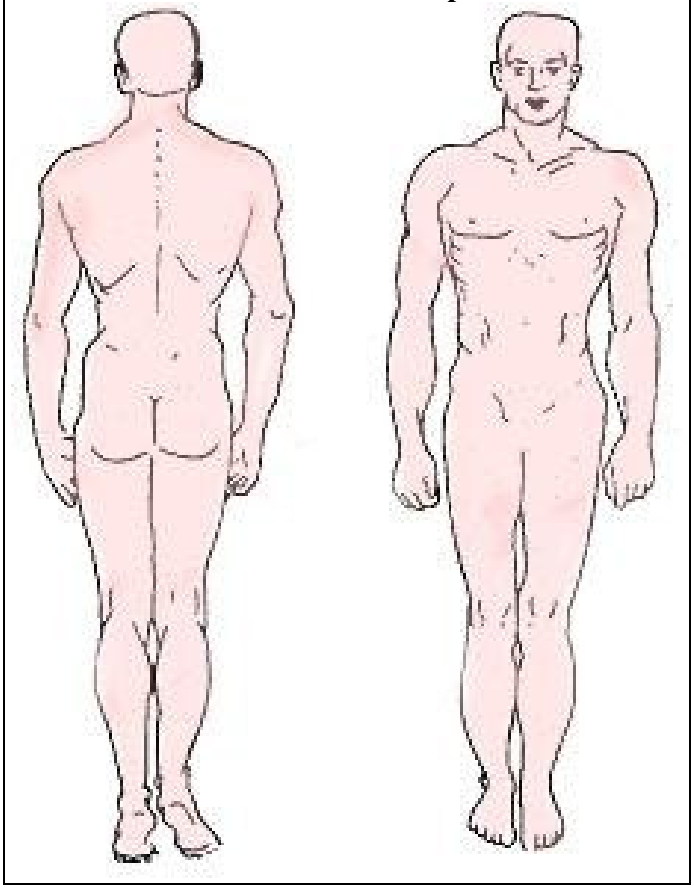
Where did you hear about our clinic, or who referred you?_____

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	Constantly or Frequently	Sometimes or Occasionally
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	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

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



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____