CHIROPRACTIC
NEUROLOGY
CENTER

9302 N.Meridian Street, Suite 170
Indianapolis, IN 46280

PATIENT INFORMATION

Welcome to our practice. Please answer the following questions. This will give the doctor valuable information needed to help you. Please be as accurate and complete as possible.

PERSONAL INFORMATION

Name: ____ Address: ______________________________________
City: ____ State: ______________ Zip: _________
Home Phone: _________________________ Date of Birth: ____ /____/______ Age: _____ Sex: M F
Business/Employer: _______________________ Work Phone: ________________ SSN: _____-____-______
Type of Work Performed: ____
Marital Status: __ M __ S __ W __ D Spouse's Name: __________________________
In Case of Emergency Notify: ___________________________________ Phone: __________________
Name of Family Physician: ____
Who referred you to our office? ____
E-mail address: ______________________________

CURRENT HEALTH CONDITION

Main or Primary Complaint:

____
____

How Severe Is This Problem:_ Mild _ Moderate _ Severe
Previous Occurrences: _ Yes _ No
When Did This Condition Begin:___________________
Other Doctors Seen For this Complaint: ____________________________________
Previous Doctor's Opinion/Diagnosis: ____________________________________
Is Condition:_ Job Related _ Auto Related _ Injury Other: __________________________________
Other or Secondary Complaints: ____
Other Health Problems: _ Yes _ No If "Yes", please describe: ___________________________
Drugs or Medicines Now Taking:
_ Pain Killers / Muscle Relaxers _ Blood Pressure Medicine _ Stomach Medicine
_ Tranquilizers _ Antibiotics Other: __________________

PAST HEALTH HISTORY

Major Surgeries/Operations: _ Head _ Neck/Throat _ Chest/Heart/Lung _ Back _ Abdominal
Other:_____________
Previous Fractures or Broken Bones: _ Yes _ No What: _________________________________
Previous Falls or Accidents: _ Yes _ No When:_________________________________
Previous Hospitalization: _ Yes _ No Why:_________________________________
Previous Chiropractic Care: _ Yes _ No Doctor:_________________________________
Has Anyone Else In Your Family Had A Similar Problem? _ Yes _ No
Has Anyone With Whom You've Worked Had A Similar Problem? _ Yes _ No
Do You Participate In Any Sports or Exercise Programs? _ Yes _ No

PLEASE COMPLETE OTHER SIDE

Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handling your case. Please complete the following as carefully as possible.

Check any of the following that applies to you:

_ Polio
_ Diabetes
_ Cancer
_ Other:___________________
_ Heart Disease
_ Chronic Fatigue

_ Arthritis
_ Epilepsy
_ AIDS or ARC
_ Frequent Illnesses
_ Allergies

INTAKE or *USE*
_ Alcohol
_ Recreational Drugs
_ Tobacco
_ Pain Relievers
_ Prescribed Drugs

Check any problem that you have had in the past 6 months:

Muscles-Skeleton
_ Low Back Pain
_ Pain Between Shoulders
_ Neck Pain
_ Arm Pain
_ Joint Pain/Stiffness
_ Problems Walking
_ Difficulty Chewing - TMJ
_ General *Stiffness*

Circulation-Breathing
_ Chest Pain
_ Shortness of Breath
_ Blood Pressure Problems
_ Irregular Heart Rate
_ Heart Problems
_ Lung Problems
_ Stroke

Eye-Ear-Nose-Throat
_ Visual Disturbances
_ Dental Problems
_ Sore Throat
_ Ear Aches
_ Difficulty Hearing
_ Stuffy Nose
_ Sinus Drainage/Pain
_ Pain - Forehead or Face

Nerve System
_ Headaches
_ Nervousness
_ Numbness/Tingling
_ Muscular Weakness
_ Dizziness
_ Forgetfulness
_ Depression
_ Fainting
_ Convulsions/Seizures
_ Cold Hands Feet
_ Stress
_ Shaking/Tremors

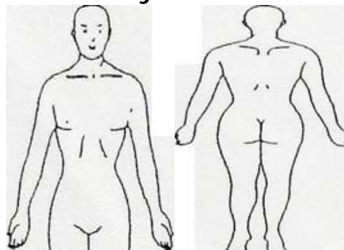
Digestion-Elimination
_ Poor Appetite
_ Excessive Thirst
_ Frequent Nausea
_ Diarrhea
_ Constipation
_ Hemorrhoids
_ Weight Loss/Gain
_ Gas/Bloating
_ Heartburn
_ Change in Stools

Urinary-Genitals
_ Pain with Urination
_ Infrequent Urination
_ Frequent Urination
_ Weak Urine Stream
_ Loss Of Bladder Control
_ Pain in Genitals

Female Only
_ Menstrual Pain/Irregularity
_ Low Back Pain w/ Periods
_ Breast Pain/Lumps

Are You Pregnant? _ Yes _ No _ Not Sure

Please mark your areas of complaint:



(X) Pain (0) Spasm (*) Numb

I understand that my care in this office may involve the making of judgments that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge. I also understand that the practice of any healing art is not an exact science and that no guarantee of results will be made by the doctor nor relied upon by me. I further understand that the doctor's professional expertise lies in detecting and correcting structural and mechanical aberrations of the spine. I agree that he will not be held responsible for the diagnosis or treatment of any medical condition.

Patient's Signature: ___________________________ Date: _____________