

Kirwan Chiropractic Centre
4708 W. Plano Pkwy., Ste. 300, Plano, TX 75093 (972) 265-8100

Name: _____ Date: _____

Address: _____

City State Zip
E-mail: _____ Cell #: _____ Home #: _____ Work #: _____

Birth Date: _____ S.S.#: _____

Single Married Divorced Widowed Number of Children: _____

Occupation: _____ Employer: _____

Spouse Name: _____ Spouse Occupation: _____

Who may we thank for referring you to our office: _____

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are first to address the issue that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Reason for seeking chiropractic care: _____

Other issues to discuss with the doctor: _____

When did you first notice this condition: _____

Have you ever had this before: Yes No When: _____

If experiencing pain, describe it:

Sharp Dull Burning Throbbing Aching Tingling Constant Travels
 Comes & Goes

What makes it worse:

Sitting Standing Walking Bending Lying Down Others _____

Since the problem started has it: Gotten better Stayed the same Getting worse

Other doctors seen for this condition:

<input type="checkbox"/> Chiropractors <input type="checkbox"/> Yes <input type="checkbox"/> No	Who: _____	When: _____
<input type="checkbox"/> Medical Doctor <input type="checkbox"/> Yes <input type="checkbox"/> No	Who: _____	When: _____
<input type="checkbox"/> Other <input type="checkbox"/> Yes <input type="checkbox"/> No	Who: _____	When: _____

Please circle all symptoms you have had in the past 6 months even if they do not relate to your current problem.

Low back pain Shoulder pain Weight trouble Neck pain Hip pain Tension across shoulders

Pain between shoulders Knee pain Tingling/Numbing in arms Tension/Headaches

Ankle/Foot pain Tingling/Numbing in legs Tired or Fatigued Ringing in ears Dizziness

Wrist/Hand pain Allergies Nervousness Elbow pain Digestive troubles Difficult sleeping

Loss of balance Irritability Stress Heartburn Constipation Diarrhea Cold hands Cold feet

Depression Hot flashes Ulcers Light bothers eyes

From birth to present:

Car Accidents (even minor ones) from childhood to present: Yes No

When: _____

Falls/Injuries (including sports) from childhood to present: Yes No

When: _____

Surgeries/Hospitalization: _____

Medications/Supplements (prescription/over-the-counter/birth control): Yes No

What: _____

On a scale of 1-10 describe your stress level (1 = none, 10 = extreme):

Occupational: _____ Personal: _____

On a scale of poor, good, and excellent, describe the following:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

X-Ray Release:

X-rays may be necessary for a complete diagnosis. This is a safe procedure, however, there is a low risk of radiation exposure. Our office does everything we can to keep your risk at a minimum. If you have any questions or concerns, please tell the doctor.

If you are pregnant or could be pregnant please advise your doctor, Even low doses of radiation could be harmful to your unborn child.

The statements made on this form are accurate to the best of my recollection, and I agree to allow this office to examine me for further evaluation.

Signature

Date