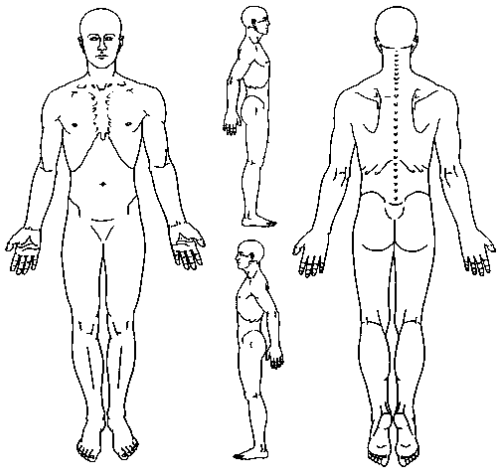
SMALL MIRACLES
NATURAL HEALTH CENTER
Chiropractic-Nutrition-Massage

Welcome to our office!

Patient Name: _____ Date of Birth: _____ Date: _____
Street Address: _____ City/Town: _____ Zip Code: _____
Cell Phone #: _____ Other #:_____ Email:_____
Age: ____ Gender: Female / Male / Non-Binary / Prefer not to answer / _____
Occupation: _____ Full Time / Part Time / Retired / Disabled / Homemaker / Student
Employer: _____ Marital Status: S / M Children? N / Y (Ages: _____)
Spouse's Name: _____ Spouse's Occupation / Employer: _____/_____
Health Insurance? Yes / No Health Savings Account / Flexible Savings Account? Yes / No
Primary Care Physician: _____ How were you referred to our office? _____
Have you received chiropractic before? Yes / No Where? _____ When was your last visit? _____
Is this condition due to a recent work injury? No / Yes Is this condition due to an auto accident? No / Yes _____
Have you hired an attorney for this injury? No / Yes: _____
When and how did your symptoms start? _____
_____
Describe your current symptoms: _____
_____
_____
List any other doctors you have consulted for this: _____
List any studies you have had: X-Rays: _____MRI: _____ Other: _____

Please mark areas of discomfort:



List Areas of Pain: ***Rate the Pain Intensity of each area of Complaint:***

1._____ **0----------10**
No Pain Worse Pain

2._____ **0----------10**
No Pain Worse Pain

3._____ **0----------10**
No Pain Worse Pain

Please check if you have had any of the following:

☐ Appendicitis	☐ Cancer	☐ Gastric Reflux	☐ High Cholesterol	☐ Osteopenia/Osteoporosis	
☐ Asthma	☐ Depression	☐ High Blood Pressure	☐ Irritable Bowel	☐ Prostate Disease	
☐ Alcoholism	☐ Diabetes	☐ Low Blood Pressure	☐ Kidney Stones	☐ Scoliosis	☐ Concussion
☐ Anemia	☐ Eczema	☐ Heart Disease	☐ Liver Disease	☐ Sinus Problems	☐ Gout
☐ Arthritis	☐ Epilepsy	☐ Hypothyroid	☐ Multiple Sclerosis	☐ Sleep Apnea	
☐ Anxiety	☐ Endometriosis	☐ Hyperthyroid	☐ Mental Disorder	☐ Stroke/TIA	
☐ Aortic Aneurysm	☐ Miscarriage	☐ HIV Positive	☐ Migraine Headaches	☐ Tuberculosis	
☐ Anorexia/Bulimia	☐ Gallstones	☐ Hemorrhoids	☐ Ovarian Cysts/PCOS	☐ Ulcer	

☐ Allergies (Please list: _____)

Other Health Conditions: _____

Height: _____ Weight: _____ Right or Left Handed? Do you wear a Heel Lift or Orthotics? No / Yes _____

Please list any current medications and the conditions they are being taken for:

Medication:	Condition:	Medication:	Condition:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check or list any previous operations and procedures:

☐ Tonsillectomy	☐ Thyroid	☐ Caesarian Section	☐ Knee (R / L)	☐ Back Surgery (Date :_____)
☐ Tubes in Ears	☐ Stomach	☐ Rectal/Colon	☐ Hip (R / L)	☐ Neck Surgery (Date :_____)
☐ Appendectomy	☐ Sinus Surgery	☐ Diverticulitis	☐ Ankle/Foot (R / L)	☐ Partial Hysterectomy
☐ Gall Bladder	☐ Hernia	☐ Carpal Tunnel (R / L)	☐ Shoulder (R / L)	☐ Complete Hysterectomy

Other Surgeries/Hospitalizations and Dates: _____
_____

Please check off any symptoms that you are currently or regularly experiencing:

☐ Fatigue	☐ Dizziness	☐ Poor Sleep	☐ Mood Swings	☐ Fever	☐ Recent Weight Loss
☐ Fainting	☐ Weakness	☐ Night Sweats	☐ Tremors	☐ Chills	☐ Recent Weight Gain
☐ Memory Loss	☐ Headaches	☐ Anxiety	☐ Twitches	☐ Seizures	☐ Sexual Dysfunction
☐ Numbness	☐ Depression	☐ Ears Ring/Buzz	☐ Dry Skin	☐ Itching	☐ Bruising Easily
☐ Muscle Cramps	☐ Nausea	☐ Skin Rashes	☐ Nose Bleeds	☐ Acne	☐ Blurred/Double Vision
☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Heartburn	☐ Reflux	☐ Excess Gas/Bloating
☐ Coughing	☐ Wheezing	☐ Palpitations	☐ Chest Pain	☐ Earache	☐ Shortness of Breath
☐ Sore Throats	☐ Sinusitis	☐ Nasal Congestion	☐ Bad Breath		☐ Jaw Pain/Clenching/Clicking
☐ Swollen Ankles	☐ Skin Rash	☐ Poor Digestion	☐ Frequent Colds		☐ Pins & Needles Sensations
☐ Incontinence	☐ Bedwetting	☐ Painful Urination			

Other symptoms that concern you: _____ _____
_____

WOMEN ONLY: ☐ Hot Flashes ☐ Irregular Cycle ☐ Painful Periods ☐ Pregnant (Due :_____)

Family History: Please check off and describe any diseases that have affected your parents or your siblings:

☐ Diabetes: _____ ☐ Heart: _____
☐ Back: _____ ☐ Cancer:_____
☐ Osteoporosis: _____ ☐ Arthritis: _____
☐ Other: _____

History of Physical and Mental Stress, Trauma, and Toxins:

How would you rate your currently level of stress? ☐ Mild ☐ Moderate ☐ Severe
Have you recently experienced any major stress events in your life? No / Yes _____
Do you exercise regularly? No / Yes Describe: _____
Previous work injuries? No / Yes Describe: _____
Previous automobile accidents? No / Yes Describe: _____
Previous sports injuries? No / Yes Describe: _____
Previous falls or other major injuries? No / Yes Describe: _____
Have you ever received an Impairment or Disability Rating? No / Yes_____
Are you currently a smoker? No / Yes (___ pack/s ____ cigarettes per day) How long have you smoked? _____ Years
Do you drink alcohol? No / Yes ☐ 0 - 7 drinks weekly ☐ 8 - 15 drinks weekly ☐ More than 15 drinks per week
Do you drink soda or energy drinks on a regular basis? No / Yes ☐ regular ☐ diet
Describe your diet: ☐ Poor ☐ Okay/Average ☐ Good ☐ Very Good ☐ Vegetarian ☐ Vegan
Do you take any vitamins or natural supplements? No/ Yes List:_____
_____

Signature of Patient or Parent/Guardian: _____ Date: _____