Queen Creek Chiropractic
3035 S. Ellsworth Rd, Ste 119
Mesa, AZ 85212
(480) 987-0585

Date: _______________

Patient Information

Describe the Reason(s) for your Visit Today: ____

____

When Did the Problem Start: ____

Name: ______________________ ______________________ __ ______________________________
Last First MI

Address: ____

Phone #: ______________________ ______________________ ______________________
Cell Phone Home Phone Work Phone

Age: _____ M__ F__ Date of Birth: ____________ Marital: M S W D # of Children: ______

Email: _________________________________ Referred By: ___________________________________

Occupation: _____________________________ Employer: ____________________________________

How do Your Symptoms Interfere with your Work or Normal Activities? __________________________

____

Are your Symptoms: (circle one) Getting Better Staying the Same Getting the Worse

How often do you Experience Symptoms? (circle one) Constantly Frequently Occasionally Intermittently

Describe your Symptoms (circle one): Sharp Dull Ache Numbing Burning Tingling Shooting

Accident Information

Is this visit due to an accident? Yes __ No __ If Yes, what type? Auto __ Work __ Other ______

Has it been reported? Yes __ No__ N/A __ If Yes, to whom? ___________________________________

Previous Injuries

Any Injuries That Did Not Heal Well? Please List Including Dates: _______________________________

____

List any Surgeries or Hospitalizations you have had including Month & Year: ______________________

____

Chiropractic Adjustment

Have you maintained your Spine with Adjustments in the Last Year? _____________________________

When was your Last Adjustment? ____________ Previous Chiropractor __________________________

Have you had recent X-Rays, MRI's, or CT's of your Neck or Back?_____________________________

Do you wear? Heal Lifts:___ Arch Support:___ Orthotics:___ Magnets:___ High Heels Regularly:___

Do you have Body Piercings? Yes___ No___ Do you have Tattoos? Yes___ No___

Name: ________________________ Date: ______________

Vitamins, Minerals, and Herbal Supplements:

Currently Taking ____

Medications:

[ ] Pain Medication [ ] Tranquilizers [ ] Anti-Depressants [ ] Steroids [ ] Birth Control

Other Medications? ___________________________ Allergies? _________________________

Unhealthy Habits:

Smoking Tobacco [Y] [N] If Yes, # per Day? ____ # of Years _____ Chewing Tobacco [Y] [N]

Alcohol: # per Week _____ Sugar: Serving per Day _____ Caffeine: Type & # per Day ___________

Overeating & Eating Poorly: How Often? ____

Healthy Habits:

Strength Training Exercises: Type & Times per Week? ________________________________

Flexibility Exercises: Times per Week? ____

Servings of Raw Fruit & Vegetables: # per Day ____________ Water: # per Day _____________

Sleep: Are you Getting at Least 7 Quality Hours per Night? ______________________________

OB/GYN: Pregnant? __________ # of Pregnancies _________ # of Children __________

Health History:

Please check to indicate if you have Ever Had any of the Following:

- [ ] Cancer
- [ ] Heart Disease
- [ ] Stroke
- [ ] High Blood Pressure
- [ ] Menstrual Problems
- [ ] Kidney Stones
- [ ] Bronchitis
- [ ] Tuberculosis
- [ ] Lung Disease
- [ ] Digestive Problems
- [ ] Emotional Disorders
- [ ] Hypothyroid
- [ ] Hyperthyroid
- [ ] Pinched Nerve
- [ ] Diabetes
- [ ] Blood Clots
- [ ] Varicose Veins
- [ ] Emphysema
- [ ] Ulcers
- [ ] Heartburn
- [ ] Weight Loss
- [ ] Weight Gain
- [ ] Fibromyalgia
- [ ] Gout
- [ ] Diarrhea Regularly
- [ ] Constipation
- [ ] Psoriasis
- [ ] Spit Up Blood
- [ ] AIDS
- [ ] Asthma
- [ ] Arthritis
- [ ] Neuralgia
- [ ] Dizziness
- [ ] Disc Problems
- [ ] Bruise Easily
- [ ] Valley Fever
- [ ] Back Pain
- [ ] Neck Pain
- [ ] Nausea
- [ ] Polio
- [ ] Sciatica
- [ ] Liver Disease
- [ ] Pacemaker
- [ ] Headaches
- [ ] Allergies
- [ ] Hot Flashes
- [ ] Eye Pain
- [ ] Fatigue
- [ ] Muscle Aches
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Loss of Balance
- [ ] Loss of Memory
- [ ] Insomnia
- [ ] Hearing Problems
- [ ] Endometriosis

Please List any Problems: ____

Family History:

List all Major Diseases Such as Cancer, Diabetes, Heart Problems, Bone/Joint Diseases and your Relationship to the Individual: ____

Signature __________________________ Printed Name _____________________ Date ___________

Signature of Parent/Guardian (if a Minor) ____