**Chandler Chiropractic | 333 N. Dobson Rd., Ste. 16, Chandler 85224 | 480.899.9855**

Name _____Address: _____

City _____ State _____ Zip _____ Cell # _____

Email _____ SSN _____

Date of Birth _____ Age _____ Weight _____ Height _____ ❑Male ❑Female

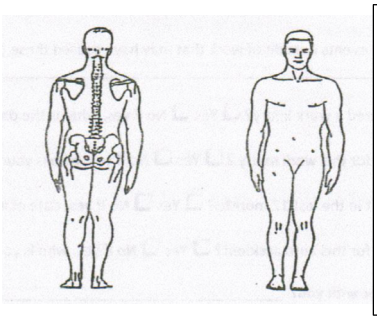
❑Single ❑Married # of children _____ Name of spouse (or parent) if applicable: _____

Employer _____ Occupation _____

Name of family physician? _____City Located? _____

Previous chiropractic care? ❑ Yes ❑ No If yes, doctor name: _____ Date of last visit _____

Circle on the diagram where your symptoms are occurring. List symptoms in order of most to least severe/length of time happening:



1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting ❑ worse or ❑ Staying the same ❑ Improving

What activities aggravate your symptoms ❑ Work ❑ Sleep ❑ Sports/Hobbies ❑ Home/Chores ❑ Focus/Concentration

Please explain (if necessary):_____

Have you at any time in the past ever suffered a work injury? ❑ Yes ❑ No If yes, what is the date of injury? _____

Have you been involved in an auto accident in the last 12 months? ❑ Yes ❑ No If yes, date of auto accident? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

Have you ever had any surgeries or hospitalizations? ❑ Yes ❑ No If yes, please list _____

_____

Please list any current or past injuries and illnesses not listed above _____

Please check all medications (over the counter and/or prescribed) currently taking: ❑ Aspirin/Tylenol ❑ Pain killers ❑ Insulin ❑ Muscle Relaxers ❑ Birth Control ❑ Sleeping pills ❑ Anti-depressants ❑ Other _____

_____

Signature: _____ Date: _____