

## Welcome to Auerbach Family Chiropractic Center!

Name \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
 Street Address \_\_\_\_\_ S.S.# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Please Check  Sex: Male \_\_\_\_\_, Female \_\_\_\_\_ Marital Status: S M W D # of Children \_\_\_\_\_  
 Who referred you, or how did you hear about us? \_\_\_\_\_

### Health History:

Is this a wellness visit \_\_\_\_\_, or for a specific concern? \_\_\_\_\_ Explain: \_\_\_\_\_  
 Describe any health concerns, including when & how they began: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you under the care of any other doctor? Yes \_\_\_\_\_, No \_\_\_\_\_  
 If Yes, the conditions being treated for: \_\_\_\_\_  
 \_\_\_\_\_

List any current Medications: \_\_\_\_\_  
 List any past surgeries & dates: \_\_\_\_\_  
 List any past accidents & dates: \_\_\_\_\_  
 List any x-rays you've had in the past 2 years: \_\_\_\_\_

### Personal & Family History:

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Children's ages and health status: \_\_\_\_\_

### Chiropractic History:

Have you ever been to a Chiropractor before? Yes \_\_\_\_\_, No \_\_\_\_\_ If Yes, Doctor's Name \_\_\_\_\_  
 Date of last chiropractic visit \_\_\_\_\_ Reason for care \_\_\_\_\_

**If you have had the following or if you suffer from the following: Please Check**

<i>Condition</i>	<i>Occasionally</i>	<i>Frequently</i>	<i>Condition</i>	<i>Occasionally</i>	<i>Frequently</i>
Headache	_____	_____	Dizziness	_____	_____
Migraines	_____	_____	Nausea	_____	_____
Neck Pain	_____	_____	Chest Pains	_____	_____
Shoulder Pain	_____	_____	Cough	_____	_____
Arm/Hand Pain	_____	_____	Weakness	_____	_____
Mid Back Pain	_____	_____	Fatigue	_____	_____
Low Back Pain	_____	_____	Nervousness	_____	_____
Hip Pain	_____	_____	Insomnia	_____	_____
Leg/Foot Pain	_____	_____	Vision Changes	_____	_____
Jaw Pain	_____	_____	Nose Bleeds	_____	_____
Disc Problems	_____	_____	Ringling in Ears	_____	_____
Arthritis	_____	_____	Earaches	_____	_____
Joint Swelling	_____	_____	Hearing Loss	_____	_____
Numbness	_____	_____	Frequent Colds	_____	_____

  

<i>Condition</i>	<i>Occasionally</i>	<i>Frequently</i>
Allergies	_____	_____
Asthma	_____	_____
Digestive Problems	_____	_____
Urinary Problems	_____	_____
Skin Conditions	_____	_____
Diabetes	Check if yes:	_____
Gout	Check if yes:	_____
Cancer	Check if yes:	_____
Osteoporosis	Check if yes:	_____
Hypoglycemia	Check if yes:	_____
Heart Problems	Check if yes:	_____
Lung Problems	Check if yes:	_____
Other :	_____	
Female Problems	_____	_____
Possibly Pregnant?	Yes _____	No _____

### Health Future:

We will work with you to restore balance to your system by offering the following **3 Phases of Care:**

1. **Release** – Release patterns of nerve interference, which may be causing loss of health.
2. **Rebuild** – Rebuild & strengthen the tone of your structural, muscular and nervous systems to prevent re-occurrences.
3. **Revitalize** – Promote an optimal state of performance & well being that adds life to your years & years to your life!

**Your Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_