Zen Chiropractic

1027 East Blvd. Charlotte, NC 28203
704-342-0996

Name_____Date____/____/____Age_____ Male/Female

Address_____City_____State_____Zip_____

Phone: Home_____ Cell_____ Cell Phone Provider_____

Email Address_____ Date of Birth_____/_____/_____

Occupation_____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages & Gender_____

_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

	Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.						
2.						
3.						
4.						
5.						

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? _____ MEDICAL DOCTOR? _____OTHER_____

WHO AND WHEN? _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	*THROAT ISSUES*	*KIDNEY PROBLEMS*	*LIVER DISEASE*	*NERVOUSNESS*
HEADACHES	*THYROID PROBLEMS*	*MID BACK PAIN*	*SHOULDER PAIN*	*EPILEPSY*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*ULCERS*	*SCIATICA*	*LUPUS*	*INFERTILITY*
NAUSEA	*NUMBNESS IN ARMS*	*NUMBNESS IN LEGS*	*FIBROMYALGIA*	*GASTRIC REFLUX*
TMJ	*NUMBNESS IN HANDS*	*NUMBNESS IN FEET*	*CHEST PAIN*	
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*OTHER*_____
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	_____
ANXIETY	*STOMACH DISORDERS*	*LEG PAINS*	_____	_____
CHRONIC SINUS	*BLADDER PROBLEMS*	*KNEE PAIN*	_____	_____

PLEASE SELECT ANY CONDITION(S) YOU HAVE NOW OR HAVE HAD:

○ Stroke	○ Cancer	○ Heart Disease	○ Surgery	○ Spinal Surgery
○ Seizures	○ Scoliosis	○ Diabetes	○ Spinal Bone Fracture	

LIST ALL SURGERIES AND YEARS PERFORMED: _____

_____

LIST ALL PRESCRIPTION MEDICATIONS: _____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT: _____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES NO

HAVE YOU EVER FRACTURED A BONE? YES NO

IF YES, PLEASE DESCRIBE: _____

OTHER TRAUMAS: _____

_____

_____

AUTHORIZATION

By signing below, I certify that I'm the patient or legal guardian listed above. I certify this information to be true and accurate to the best of my knowledge. Since chiropractic care should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the doctor updated as to any changes in my medical profile and understand that there shall be no liability on the doctor's part should I forget to do so. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctor sees fit. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for payment of such services. I understand that chiropractic care may cause temporary physical discomfort as my body adjusts to the new alignment.

_____	_____	_____
NAME OF PATIENT OR GUARDIAN	PATIENT OR GUARDIAN SIGNATURE	DATE
_____	_____	_____
NAME OF CHIROPRACTOR	CHIROPRACTOR SIGNATURE	DATE