WELCOME! SO HAPPY TO MEET YOU!

Please tell us about yourself:

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: ____ Email address: _____

Type of work: _____ Cell Phone: _____

Employer: _____ Height: _____ Weight: _____

Why are you coming in to see us? (please describe your issue):_____

_____

How did this happen? _____

Does anything make it better? _____ Does anything make it worse? _____

Have you seen anyone else for this problem? _____

Where would you rank your health today on a health scale:

Excellent ❑	Very Good ❑	Good ❑	Transitional ❑	Challenged ❑	Very Challenged ❑
95-100%	90-94%	80-89%	70-79%	60-69%	0-59%

Where would you like your health to be? _____

What could make your life healthier? _____

Have you had previous chiropractic care? ❑ Yes ❑ No If yes, what were your results?

_____

Please list any surgeries and dates:_____

_____

Please list any medications, supplements or vitamins that you are taking:_____

_____

Do you exercise? ❑ Yes ❑ No If yes, what type, how much and how often?_____

Do you drink water? ❑ Yes ❑ No If yes, how much and how much per day? _____

Do you Smoke? ❑ Yes ❑ No If yes, how much and how much per day? _____

Do you have any root canals/metals/implants? ❑ Yes ❑ No If yes, where? _____

How many fruits and vegetables do you eat per day? _____

What activities do you love to do? _____

What do you do to relax? _____

Have you ever experienced any issues with the systems or areas listed below: Your answers enable us to help guide you to reach your health goals. **Please mark an Y for past and X for present.**

Allergies or Sinuses	Anxiety	Immune System
Arthritis	Asthma	Ear, Eyes, Nose or Throat
Osteoporosis	Cancer	Circulation Problems (cold feet/hands)
Bladder/Urine/kidney	Reproductive organs	Constipation/Diarrhea
Mid-Back	Dizziness or Vertigo	Headaches
Neck	Head Trauma/concussion	Fatigue
Low back	Menstrual Cramps	Difficulty sleeping
Shoulder	Numbness/Tingling	Mood Swings/Depression
Hands or Feet	Heart	High Blood Pressure
Skin Conditions	Liver	Frequent colds, flu
Nerves	Gallbladder	Muscles or tissues
Loss of balance	Pancreas	Lungs or breathing
Car Accident(s)	Kidneys	Emotional Stress or Trauma
Acid Reflux	Stomach	Digestion
Heartburn	Spleen	Gastrointestinal Issues: IBS/Crohn's Etc.
Other:	Other:	Other:

Is there a chance you're pregnant? ❑ Yes ❑ No If so, how many weeks? _____

GOALS: Which best describes the outcome you are looking for?
❑ Specific concern and only require help with this concern
❑ I would like to ensure my health concerns don't become an ongoing problem impacting my future health
❑ 5 years from now, I would like to be healthier than I am today

I the undersigned agree that I am responsible for payment for all services rendered by Precise Moves Chiropractic. I clearly understand and agree that all services rendered to me are charged directly to me and I am personally and financially responsible whether or not insurance submits payments.

Patient/Parent: _____ Date: _____