



PLEASE PRINT CLEARLY AND FILL IN COMPLETELY - FRONT AND BACK

Name _____ Age _____ Phone _____
Street Address _____ Cell _____
City _____ State _____ Zip _____ Date of Birth _____
Email _____
Preferred way to contact you _____

Health History:

Problem area(s): _____ Work related? Yes No
Date of onset: _____ Sudden Gradual Duration: min hrs days months years
Pattern of problem: Constant Intermittent Occasional
Initiating Factors: _____
What makes it better? _____
What makes it worse? _____
List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

Personal & Family History:

Occupation: _____ Employer _____
Marital Status: Married Single Divorced Widowed Other
Spouse's name and health status: _____
Children's names, 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 _____
Date of last chiropractic x-rays _____ How long were you under care? _____

Wellness Commitment

At Gorman Chiropractic Life Centers we are dedicated toward achieving the goal of total lasting health for our patients. To better help you achieve this; we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining your health and wellness.

10%----- 20% -----30% ----- 40% -----50% ----- 60% -----70% ----- 80% -----90% ----- 100%

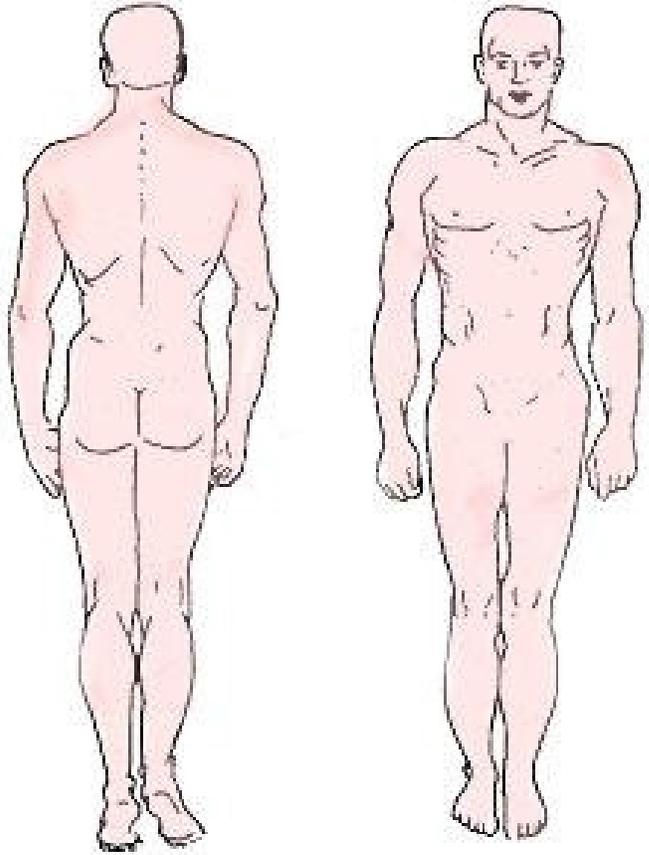
Where did you hear about our office or who referred you? Friend
Flyer Newspaper Radio Sign Social Media Other

Please Fill in Below

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

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Grating/Grinding Neck	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>
Pins and Needles	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Faulty Posture	<input type="checkbox"/>	<input type="checkbox"/>
Painful Periods	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Cycles	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant AT This Time	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

Thank you for being complete and thorough.