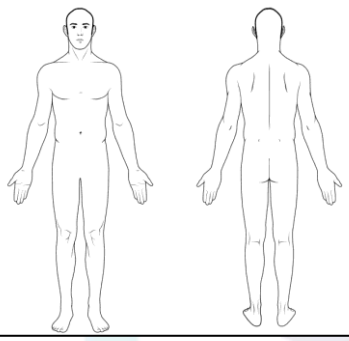
CAROLINA FAMILY CHIROPRACTIC LLC

First Name:	Last Name:	Date:
SS#:	DOB:	Sex: ◯ M ◯ F
Marital Status:	Number of Children:	Occupation:
Street Address:		Height:
City, State, Zip:		Weight:
Email:	Cell Phone:	Other:
Emergency Contact:	Relation:	Phone:
How did you hear about us?		
Who is your Primary Care Physician?		
Date/Reason for last doctor visit:		
Are you also receiving care from any other health professionals? ◯ Yes ◯ No If yes, please name them and their specialty:		
Please note any significant family medical history:		

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort
X=Current O= Past



Have you received care for this problem before? ◯ Yes ◯ No
If yes, please explain:

When did the condition first begin?

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-injury

Is this condition: ◯Getting worse ◯Improving ◯Intermittent ◯Constant

What makes the problem better?

What makes the problem worse?

Your top 3 health goals:

1._____

2._____

3._____

keeping the backbone of your family healthy

What would you like to gain from Chiropractic care?
◯ Resolve existing condition(s) ◯ Overall ◯ Wellness ◯ Both

Do you have any health concerns for other family members today?

Have you ever had any significant falls, surgeries, or other injuries as an adult? ◯ Yes ◯ No
If yes, please explain:

Notable childhood injuries? ◯Yes ◯ No If yes, please explain:

Youth/College Sports? ◯Yes ◯ No If yes, please explain:

Any Auto Accidents? ◯ Yes ◯ No If yes, please explain:

Exercise frequency? ◯None ◯1-2x/week ◯ 3-5x/week ◯ Daily
What type of exercise?

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach
Do you wake up? ◯ Refreshed and ready ◯ Stiff and tired

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes daily?

List any problems with flexibility: (i.e. putting shoes on, etc.)

How many hours per day do you typically spend sitting at a desk or on a computer, tablet, or phone?

Please rate your CONSUMPTION of each:

	None		Moderate		High
Alcohol	◯	◯	◯	◯	◯
Water	◯	◯	◯	◯	◯
Sugar	◯	◯	◯	◯	◯
Dairy	◯	◯	◯	◯	◯
Gluten	◯	◯	◯	◯	◯

	None		Moderate		High
Processed foods	◯	◯	◯	◯	◯
Artificial sweeteners	◯	◯	◯	◯	◯
Sugary Drinks	◯	◯	◯	◯	◯
Cigarettes	◯	◯	◯	◯	◯
Recreational Drugs	◯	◯	◯	◯	◯

Please list any drugs/medications/vitamins/herbs/other that you are taking & why:

Please rate your STRESS for each:

	None		Moderate		High
Home	◯	◯	◯	◯	◯
Work	◯	◯	◯	◯	◯
Life	◯	◯	◯	◯	◯

	None		Moderate		High
Money	◯	◯	◯	◯	◯
Health	◯	◯	◯	◯	◯
Family	◯	◯	◯	◯	◯

I hereby authorize Dr. Ekstam to examine me, including x-rays if indicated by my exam, and to release records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me.

By signing your name below, you certify the accuracy of your medical and/or accident history and further certify that you present to Carolina Family Chiropractic for evaluation and treatment of a health related condition and for no other purpose.

Patient Name:_____ Date:_____