FACKLER FAMILY CHIROPRACTIC, LLC

PLEASE PRINT

TODAY'S DATE: _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ *E-MAIL ADDRESS _____

BIRTH DATE ____/____/____ SOCIAL SECURITY # _____ - _____ - _____

MARITAL STATUS S M W D SEX M___ F___ # OF CHILDREN _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

WORK PHONE # (_____) _____ - _____

SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____

NAME OF REFERRER _____

(P)ATIENT (D)OCTOR (O)THER

MEDICARE PATIENT'S ONLY

MEDICARE # _____ - _____ - _____

SECONDARY INSURANCE CARRIER _____

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WHAT HAS BROUGHT YOU TO THIS OFFICE? _____

DATE CONDITION BEGAN _____ SIMILAR SYMPTOM'S IN PAST? _____

ACTIVITIES THAT AGGRAVATE CONDITION _____

ACTIVITIES THAT ALLEVIATE CONDITION _____

HAVE YOU SEEN A CHIROPRACTOR BEFORE? _____ WHO? _____ WHEN? _____

HAVE YOU SEEN A DOCTOR FOR THIS CONDITION? _____ WHO? _____

*Please fill out so that we may notify you with any updates or appointment reminders

PLEASE FLIP OVER

MEDICATIONS TAKING PRESENTLY: _____

_____

SUPPLEMENTS TAKING PRESENTLY: _____

_____

LIST ANY SURGERIES, BROKEN BONES/DISLOCATIONS, HOSPITALIZATIONS _____

_____

ANY BAD FALLS? _____

ANY KNOWN ALLERGIES? _____

DO YOU DRINK COFFEE? _____ HOW MANY PER DAY? _____ OTHER? _____

DO YOU SMOKE? _____ HOW MUCH PER DAY? _____ HOW LONG? _____

HOW MUCH WATER DO YOU DRINK PER DAY? _____

WOMEN PATIENT'S ONLY

PREGNANT? _____ FIRST DAY OF LAST MENSTRUAL PERIOD? _____

HAVE YOU TAKEN ANY HORMONE REPLACEMENTS (INCLUDING BIRTH CONTROL)? _____

WHEN AND FOR HOW LONG _____

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PLEASE CHECK ONE OF THE FOLLOWING

I'VE COME TO YOUR OFFICE TO FIND OUT MORE ABOUT CHIROPRACTIC BECAUSE:

_____ THE DOCTOR CAME HIGHLY RECOMMENDED

_____ WHAT I ALREADY KNOW ABOUT CHIROPRACTIC MAKES SENSE.

_____ I CAN'T SEE MYSELF HAVING SURGERY OR TAKING MEDICATION THE REST OF MY LIFE.

Name:_____

REVIEW OF SYSTEMS

PLEASE CHECK THE CONDITIONS YOU HAVE NOW, OR HAVE HAD IN THE PAST

Headaches/Migraines _____
Dizziness _____
Sleeping Problems _____
Epilepsy _____
Blurred Vision _____
Anemia _____
Vision Loss _____
Hardening of the Arteries _____
Blood Vessel Disease _____
Temporary Lack of understanding _____
Diabetes _____
Numbness/Cramps _____
Rheumatic Fever _____
Hearing Loss _____
Ringing in ears _____
Difficulty Swallowing _____
Abnormal Sensation in arms, or any part of body _____
Autoimmune Disease _____
High Blood Pressure _____
Low Blood Pressure _____
Heart Disease _____
Hay Fever/Sinus _____
Cancer _____
Double Vision _____
Nausea _____
Sudden Collapse w/o loss of consciousness _____
Loss of Consciousness momentary blackout _____
Constipation/Diarrhea _____

Scoliosis _____
Stroke _____
Digestive Problems _____
Sciatica _____
Slurred or problem w/ Speech _____
Weakness, Clumsiness, Loss of Strength in Face, Fingers, Hands or Legs _____
Chronic Fatigue _____
Fibromyalgia _____
Abnormal Fatigue _____
Adult Acne _____
Gallbladder Problems _____
Infertility _____
Insomnia _____
Osteoporosis _____
Indigestion _____
Acid Reflux _____

FEMALES ONLY: _____
PMS _____
Fibroids _____
Irregular Periods _____
Hysterectomy _____
Endometriosis _____
Spotting _____
Anxiety _____
Ovarian Cysts _____
Cyclical Irritabilty _____

Other: _____

FAMILY HISTORY:

Indicate relationship of blood-family member with these conditions:

Heart Disease _____
Diabetes _____
Scoliosis _____
Arthritis _____
Cancer _____

Low Blood Sugar _____
Stroke _____
High Blood Pressure _____
Osteoporosis _____
Other _____