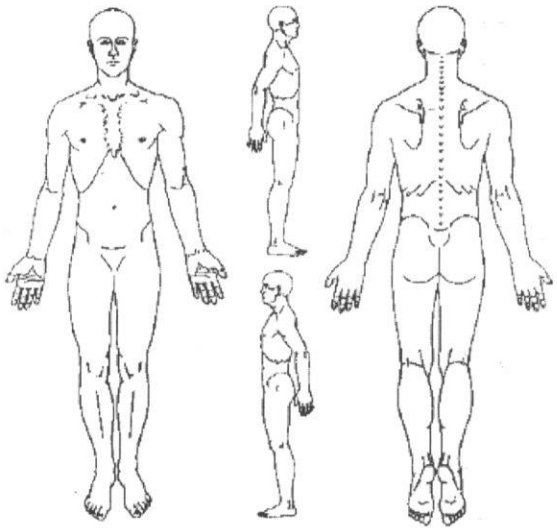
botha chiropractic
spinal correction center

CONTACT INFORMATION

Name:
Address:
City: State: Zip:
Phone (H):
Phone (Cell):
Phone (W):
Email:
Date of Birth: Age:
Gender: □ Female □ Male
Marital Status S M D W
Referred by:

Occupation:
Employer:
Spouse's Name:
Spouse's Occupation:
Emergency Contact:
Relationship:
Phone (Cell):
Phone (Other):
Would you like us to check your Insurance? □ YES □ NO
Company: SS #:

CURRENT/PRESENT HEALTH HABITS & PROBLEMS



Please Mark

- **Present Complaint(s):**
- **When did the pain/problem start:**
- **What is the type of pain you are experiencing?**

□ Sharp □ Dull □ Aching □ Numbness □ Throbbing □ Other

- **What is the severity of your pain?**

Least Pain - 1 2 3 4 5 6 7 8 9 10 - Severe Pain

- **Is your problem worse at certain times of the day?**

□ Morning □ Afternoon □ Evening □ Night □ Other

- **Are there any activities/movements that are painful to perform?**
- **Is this condition getting progressively worse?** □ YES □ NO
- **Does the problem/condition refer anywhere?** (Ex: into right arm)
- **What have you done for the problem/condition?** (Ex: ice/heat)

How many times have you visited a Chiropractor in your lifetime? _____ □ Never

When was your last complete spinal examination including x-rays? _____ □ Never

Have you ever been told that you have a spinal curvature, arthritis, or inherited spinal problem? □ YES □ NO

Rate your stress level over the last 90 days. [Low - 1 2 3 4 5 6 7 8 9 10 - High]

Is today's visit related to any one of the following: □ Work Related □ Auto Accident □ Home Injury □ Fall □ Other

WOMEN ONLY: Are you pregnant? □ YES □ NO

Date of onset of last menstrual cycle: _____

Do/Did you smoke?	□ YES	□ NO	Do you drink coffee/caffeine?	□ YES	□ NO
Do you exercise regularly?	□ YES	□ NO	Do you eat fast-food?	□ YES	□ NO
Do you have stress?	□ YES	□ NO	Do you consume white sugar?	□ YES	□ NO
Do you drink alcohol?	□ YES	□ NO	Do you use artificial sweeteners?	□ YES	□ NO

FAMILY HEALTH HISTORY

It is well known that families who maintain strong healthy, well-aligned spines have much improved health.

Spouse Name:	Age:	Health Challenge: (ex: Fatigue)
Child Name:	Age:	Health Challenge: (ex: Hyperactivity)
Child Name:	Age:	Health Challenge: (ex: ADHD)
Child Name:	Age:	Health Challenge: (ex: Bedwetting)
Child Name:	Age:	Health Challenge: (ex: Allergies)

Please Mark the Following:	Father	Mother	Spouse	Siblings	Children
Cancer	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐
Sinus & Allergies	☐	☐	☐	☐	☐

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
- ☐ Arm Pain
- ☐ Difficulty Chewing
- ☐ General Stiffness
- ☐ Herniated Disk
- ☐ Jaw Pain/Clicking Jaw
- ☐ Joint Pain/Stiffness
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Pain Between Shoulders
- ☐ Walking Problems

C-V-R CODE
- ☐ Chest Pains
- ☐ Ankle Swelling
- ☐ Asthma
- ☐ Heart Problems
- ☐ High/Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Lung Problems/Congestion
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Varicose Veins

NERVOUS SYSTEM CODE
- ☐ Cold/Tingling Hands or Fee
- ☐ Confusion/Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Loss of Balance
- ☐ Loss of Memory
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nervousness
- ☐ Numbness
- ☐ Pinched Nerves
- ☐ Pins and Needles
- ☐ Stress/Tension

GENITO-URINARY CODE
- ☐ Bladder Trouble
- ☐ Discolored Urine
- ☐ Painful/Excessive Urination

EENT CODE
- ☐ Sinus Problems
- ☐ Dental Problems
- ☐ Ear Aches
- ☐ Ears Ring
- ☐ Hearing Difficulty
- ☐ Sore Throat
- ☐ Visual Problems

GEN CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Fever
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Migraines

GASTRO-INTESTINAL CODE
- ☐ Abdominal cramps
- ☐ Constipation
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Gall Bladder Problems
- ☐ Gas/Bloating After Meals
- ☐ Heartburn/Indigestion
- ☐ Liver Problems
- ☐ Poor/Excessive Appetite
- ☐ Ulcers
- ☐ Vomiting
- ☐ Weight Problems

FEMALES ONLY
- ☐ Menstrual Irregularity
- ☐ Trouble Getting Pregnant
- ☐ Menstrual Cramps
- ☐ Miscarriage

Are you pregnant?
☐ YES ☐ NO ☐ Unsure

HAVE YOU BEEN DIAGNOSED WITH HAVING:

- ☐ *Broken Fractured Bones
- ☐ *Cancer
- ☐ *Diabetes
- ☐ *Osteoarthritis
- ☐ *Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Asthma
- ☐ Circulatory Problems
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Excessive/Bleeding Disorde
- ☐ Gout
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Hernia
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Prosthesis
- ☐ Seizures/Convulsions
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Other: _____
- ☐ Other: _____

*Explanation: _____

LIST MEDICATIONS:

_____

_____

_____

_____ _____

Patient Signature ***Date***