

Name: _____ Date: _____

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

Email: _____ Occupation: _____

Phone: _____ Cell: _____ Work Phone: _____

DOB: _____ Age: _____ Married Single Divorced Widowed Kids: _____

Referred By/How did you hear about us: _____

YOUR CHILDHOOD YEARS (TO AGE 17)

	YES	NO		YES	NO
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	Have you fallen / jumped Fall from a height over three feet?	<input type="checkbox"/>	<input type="checkbox"/>
Did you take medications? (antibiotics, inhaler etc)?	<input type="checkbox"/>	<input type="checkbox"/>	Any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>
Did you have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>

Please share any additional information:

ADULT - (18 TO PRESENT)

	YES	NO		YES	NO
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you play adult sports?	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries

Type _____ When _____

Type _____ When _____

Medications

Type _____ For _____ How Long _____

Type _____ For _____ How Long _____

Type _____ For _____ How Long _____

Any side effects or complications _____

Do you try to avoid taking medications? YES NO

Would you like to decrease the amount of medication you are currently on? YES NO N/A

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no symptoms or complaints, and are here for wellness services, please check here: _____

Otherwise please briefly explain what brought you to our office today:

This interferes with: ___Work ___Sleep ___Walking ___Hobbies ___Family ___Leisure ___Other

How does it interfere: _____

Additional concerns: _____

Have you seen anyone else for this issue? ___yes ___no If yes, who? _____

What was the result _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Mid back pain/stiffness | <input type="checkbox"/> Low Back pain/stiffness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> General tension |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Constipation | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Mental fog | <input type="checkbox"/> Digestive trouble | <input type="checkbox"/> Urinary Problem | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Extremity pain |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Change in weight | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> TMJ problems |

Other(s) _____

LIFESTYLE QUESTIONS

- | | YES | NO | | YES | NO |
|-------------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|
| Do you eat a healthy diet? | <input type="checkbox"/> | <input type="checkbox"/> | Belong to a health club? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get quality sleep? | <input type="checkbox"/> | <input type="checkbox"/> | Watch 5 hours of TV per week? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get adequate exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Use computer 2 hours a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink enough water? | <input type="checkbox"/> | <input type="checkbox"/> | Sit more than 10 hours a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Use vitamins? | <input type="checkbox"/> | <input type="checkbox"/> | Do you try to improve your health? | <input type="checkbox"/> | <input type="checkbox"/> |

Rank your emotional health? Poor Fair Good Excellent

Rank your occupational health? Poor Fair Good Excellent

Rank your overall health? Poor Fair Good Excellent

I consent to a complete chiropractic examination and to any radiographic examination the doctor deems necessary.

Signature _____

JUNGE FAMILY CHIROPRACTIC

4164 18th Ave, NW Rochester, MN 55901
(507) 208-4481 www.JungeFamilyChiropractic.com