PEAK POTENTIAL
FAMILY CHIROPRACTIC

Name: _____ Age: _____ Date: _____

Birth Date: _____ Male: _____ Female: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Email Address: _____

Occupation: _____

Employer Name: _____

Single: _____ Married: _____ Spouse's Name: _____

Have you seen a Chiropractor Before? Yes_____ No_____ If yes, when? _____

Whom may we thank for referring you to our office? Or how did you hear of us? _____

YOUR HEALTH SUMMARY

Please check all symptoms related to your current problem.

___ Headaches	___ Pins & needles in legs	___ Fainting	___ Neck pain
___ Pins & needles in arms	___ Loss of smell	___ Back pain	___ Loss of balance
___ Dizziness	___ Buzzing in ears	___ Ringing in ears	___ Nervousness
___ Numbness in fingers	___ Numbness in toes	___ Loss of taste	___ Stomach upset
___ Fatigue	___ Depression	___ Irritability	___ Tension
___ Sleeping problems	___ Neck stiffness	___ Cold hands	___ Cold feet
___ Diarrhea	___ Constipation	___ Fever	___ Hot flashes
___ Cold sweats	___ Light bothers you	___ Problem urinating	___ Heartburn
___ Mood swings	___ Menstrual pain	___ Menstrual irregularity	___ Ulcers

List any medications you are taking _____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date_____

Guardian Signature_____ Date_____