

Welcome to Boyd Chiropractic Center

Date _____

Name (Mr. Ms. Mrs. Dr) _____ Sex M F Marital Status M S W D

Date of Birth _____ Age _____ SS Number _____ Drivers License # _____

Address _____

City, State & Zip _____

Home Phone _____ Work _____ Cell _____

E-mail address _____ Employer _____

Employers Address _____

Nearest Relative, address and phone _____

Who may we thank for referring you to our office or how did you hear about our office _____

Past chiropractic Care () Yes () No Who & When _____

Results _____

Name of your insurance company _____

Spouses Name _____ DOB _____ Occupation _____

Spouse employer _____ Spouses work # _____

Main reason(s) for consulting our office _____

Who else have you consulted for this _____

Is your present condition due to an injury? () yes () no () on the job () Auto Collision () Personal Injury

Has the accident been reported? () Employer () Auto insurance () Work Comp () Other

Have you retained an Attorney () yes () no Name & phone # _____

Are you now or ever been disabled () yes no () When _____

Date of your injury or first symptom _____ Date of your last x-ray _____

For women only: are you or could you be pregnant () yes () no

1. _____
0 1 2 3 4 5 6 7 8 9 10

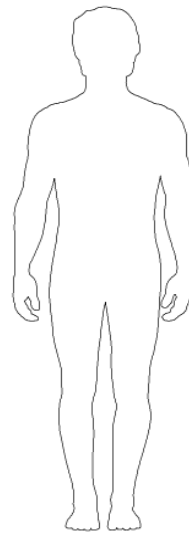
2. _____
0 1 2 3 4 5 6 7 8 9 10

3. _____
0 1 2 3 4 5 6 7 8 9 10

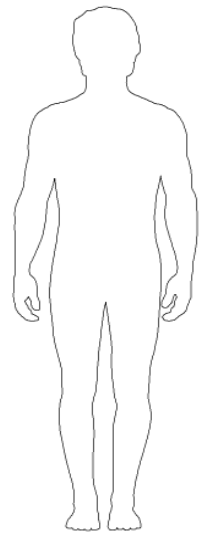
4. _____
0 1 2 3 4 5 6 7 8 9 10

5. _____
0 1 2 3 4 5 6 7 8 9 10

Please mark on the drawing where your pain is. Then on the lines to the side, mark on a scale of 0 to 10: 0 being no pain 10 being severe suicidal pain, mark how it feels to you.



Front



Back

Have you had any of the following?

- | | | | |
|----------------|--------------------|--------------------------|----------|
| Pneumonia | Heart Disease | Rheumatic Fever | Pleurisy |
| Polio | Alcoholism | Encephalitis | ADHD |
| Tuberculosis | Venereal infection | Mental Disorder | Measles |
| Whooping cough | Arthritis | Anemia | Epilepsy |
| Mumps | AIDS | Cancer (what kind) _____ | |

Habits		Family History				
() Smoking	Packs / day _____	Diabetes	Heart	Kidney	Cancer	Back
() Drinking	Alcohol _____ Day/wk	Mother	()	()	()	()
() Coffee	Cups / day _____	Father	()	()	()	()
() Pop	Cans / day _____	Brothers # _____	()	()	()	()
		Sisters # _____	()	()	()	()
Exercise () None () Moderate () Daily						
Names and ages of Children _____						

Every one has had a headache at one time or another, so what I am concerned about is if your have had a serious or long term problem with any of the following. Please Enter: "2" (previously), "3" (presently) in front of the all of the following signs and symptoms. A complete history and understanding of your health will help in your care. Leave blank if not applicable.

Muscles and Joints	Convulsions	Constipation	Eye/Ear/Nose/Throat	Genito-Urinary
Weakness	Loss of sleep	Diarrhea	Poor Vision	Skin or Allergies
Stiff neck	Fatigue	Colon trouble	Crossed Eyes	Skin Eruptions
Backache	Nervousness	Hemorrhoids	Pain in Eyes	Itching
Swollen Joints	Loss of weight	Liver trouble	Deafness	Bruising Easily
Tremors / Twitching	Numbness in arms or legs	Gallbladder	Earache	Dryness
Foot Trouble	Pain in arms or legs	Cardiovascular	Ear Noises	Sensitive Skin
Painful tailbone	allergies (what)	Rapid Heart beat	Ear Discharge	Hives or Allergy
Pain between the shoulders	Gastro-Intestinal	Slow Heart Beat	Nose Bleeds	Eczema
Hernia	Poor appetite	High Blood Pressure	Sore Throat	Medicines
Spinal curvature/scoliosis	Poor Digestion	Low Blood Pressure	Hoarseness	Respiratory
General Symptoms	Excessive hunger	Pain over the heart	Hay Fever	Chronic Cough
Headache	Belching or Gas	Previous heart Trouble	Asthma	Spitting Blood
Fever	Nausea	Poor Circulation	Frequent Colds	Spitting Phlegm
Chills	Vomiting	Varicose Veins	Enlarged Thyroid	Chest Pain
Fainting	Vomiting Blood	Strokes	Tonsillitis	Difficulty Breathing
Dizziness	Pain over the stomach		Sinus Trouble	
				For Women Only
				Painful Periods
				Excessive Flow
				Irregular Cycle
				Hot Flashes
				Cramps or Backaches
				Miscarriage
				Vaginal Discharge
				Pregnant at This Time Yes / No

Please list any Operations or Procedures that you have had along with the date(s)

List any broken bones or dislocations

Ever on crutches? Yes No Why? _____

Have you ever had a spinal tap or spinal injection? Yes No _____

Have you ever been knocked unconscious? Yes No _____

Have you ever had a lapse of memory? Yes No _____

Have you ever had x-rays or MRI's CAT scans taken? Yes No When? _____ Where? _____

For what ailments were these made? _____

Do you suffer from any other condition other than what you are consulting us for now? Yes No What? _____

Are you taking any medication -- Prescription or over the counter ? Yes No What? _____

List any accidents or falls. Car _____ Recreational vehicle _____

Sports _____ School _____ Other _____

Informed consent waiver and authorization to treat.

I, the undersigned acknowledge by my signature that I am aware that Dr David Boyd is a licensed chiropractor, and although rare, injury resulting from manipulation may include stroke, death, disc herniation and other injuries or complications. I here by agree to hold the treating chiropractor harmless from any liability, claims, demands, or suits for damages from any treatment or complications whatever, which may result from such treatment.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or any medical diagnosis.

Patients Signature _____ Date _____