John D. Pinnix, D.C.

ChiroBus – a Mobile Chiropractic Clinic

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NEW PATIENT

Patient Name_____ **Age** ____ **Date** _____

Address _____ **City** _____ **State** ___ **Zip** _____

Home Phone _____**Date of Birth**_ _____ **Cell Phone**_____

Social Security # _____ **Email address** _____

Employer _____

Job Description _____ **How long employed?** _____

Have you been to a Chiropractor in the past? No ____ **Yes** ____ **If yes, date of last Chiropractic visit** _____

Who may we thank for referring you to our clinic? _____

Have you seen the ChiroBus while you were out driving? _____

Number of Children, & their ages _____

Spouse's Name _____**Cell Phone** _____

Spouse's Employer _____

Spouse's email address _____**Spouse's job description** _____

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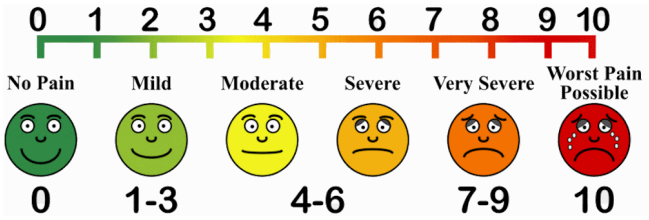
What is your #1 Current complaint? _____



Is this a New Complaint or a recurring one? _____

How often do you experience this complaint?

____ 0 – 25% of the time ____26 – 50% of the time ____ 51 – 75% of the time ____ 76 – 100% of the time

Did this complaint come on suddenly or gradually? _____

What activities are you unable to perform comfortably due to this complaint? _____

_____

What caused this complaint? _____

Have you had this complaint or a similar complaint in the past? _____

Chiropractor's Comments: _____

_____

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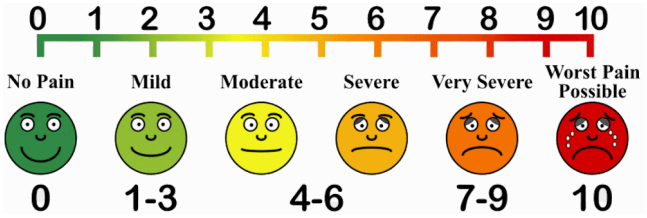
What is your #2 Current Complaint? _____



Is this a New Complaint or a recurring one? _____

How often do you experience this complaint?

____ 0 – 25% of the time ____26 – 50% of the time ____ 51 – 75% of the time ____ 76 – 100% of the time

Did this complaint come on suddenly or gradually? _____

What activities are you unable to perform comfortably due to this complaint? _____

_____

What caused this complaint? _____

Have you had this complaint or a similar complaint in the past? _____

Chiropractor's Comments: _____

_____

****

List Any Other Current Complaints: _____

_____

Is (Are) this/these a New Complaint(s) or a recurring one(s)? _____

Did this/these complaint(s) come on suddenly or gradually? _____

What activities are you unable to perform comfortably due to this/these complaint(s)? _____

_____

What caused this/these complaint(s)? _____

_____

Have you had this/these complaint(s) or a similar complaint in the past? _____

Chiropractor's Comments: _____

_____

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List ANY AND ALL Surgeries and approximate dates or ages when you had them: _____

_____

_____

Chiropractor's Comments: _____

_____

List ANY AND ALL Medications, Vitamins, or Supplements you are currently taking: _____

_____

_____

Chiropractor's Comments: _____

_____

List ANY AND ALL previous accidents or injuries & Approximate dates. These could be falls, spills, auto accidents, work accidents, sports injuries, or any other injury :

_____

_____

_____

_____

Please check off any of the following that YOU OR ANYONE IN YOUR FAMILY suffer from, past or present:

If it something that you have put P, if it is your father put F, mother put M, sister S, etc.

Asthma _____ Arthritis _____ Cancer _____ Heart Disease _____

Stroke _____ High Blood Pressure _____ Ulcers _____ Parkinson's Disease _____

Alzheimer's _____ Back or Neck Problems _____ Neurogical Disorders _____ Dementia _____

Diabetes _____ Gout _____ Gastrointestinal Disorders _____ Cataracts _____

Skin Disease_____ Macular Degeneration _____ Depression _____ Psychological Disorders _____

Other Diseases or Conditions _____

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Is there anything else you want the doctor to know about you? _____

_____

_____

What do you hope to achieve during today's visit? _____

_____

_____

Do you have any specific questions for the doctor? _____

_____

_____

Patient's Signature_____ **Date** _____

Parent or Guardian's Signature _____ **Date** _____