Maan Chiropractic 8100 Royal Palm Blvd #106. Coral Springs, FL 33065 Tel: (954) 225 – 4007

First Name:_____**Last Name**:_____

Date of Birth: _____/_____/_____ **Gender**: M / F **Marital Status**: SINGLE / MARRIED / WIDOWED

Address: _____**Apt#**_____

City: _____**State**:_____**Zip**:_____

Cell Phone (_____) _____-_____ **Home Phone** (_____) _____-_____

Email address: _____

Occupation: _____

How did you hear about our office? _____

Do you have insurance? YES OR NO, If yes, please fill out below

Insurance Name: _____ **ID#** _____

Emergency Contact: _____**Phone #** (_____) _____-_____

Your Primary Care Doctor: _____**Phone #** (_____) _____-_____

I understand and agree to update the office immediately in changes of responsible financial party information, insurance information, and any other changes in my health condition as soon as possible.

_____ _____/_____/_____

Patient or Guardian's Signature **Today's Date**

NAME:_____ **DOB:**_____/_____/_____

PATIENT INFORMATION

PLEASE CIRCLE ALL YOUR PREVIOUS AND CURRENT ILLNESSES: *NONE*

Arthritis	AutoImmune Problems	Tendinitis	Asthma
Allergies	Sinus Trouble	Tuberculosis	Diabetes
Bone Fracture	Dislocated Joints	Epilepsy	Ulcer
Spinal Disc Disease	Thyroid Trouble	Multiple Sclerosis	Fibromyalgia
High Blood Pressure	Low Blood Pressure	Heart Trouble	Prostate Trouble
Heart Disease	AIDS/ HIV /STD	Depression/Anxiety	Kidney Disease
Disc Herniation	Sciatica	Pinched Nerve	Scoliosis
Serious Injury	Other: _____		

Have you ever had a STROKE?	NO	YES	If yes, when?_____
Have you ever had SEIZURES?	NO	YES	If yes, when?_____
Have you ever had CANCER?	NO	YES	If yes, when?_____
Do you have OSTEOPOROSIS?	NO	YES	
Do you have PACEMAKER?	NO	YES	
Are you or could you be PREGNANT?	NO	YES	If yes, due date?_____
Have you ever had a CAR or other ACCIDENT?	NO	YES	If yes, what year?_____
Pain when you cough/sneeze/bowel movement?	NO	YES	
Are you currently taking any MEDICATIONS?	NO	YES	

If yes, please list:_____

Do you have ALLERGIES to any medications? NO YES

If yes, please list:_____

Have you ever had any SURGERY? NO YES

If yes, please list:_____

FAMILY HISTORY: DO ANY OF YOUR PARENTS OR SIBLINGS SUFFER FROM

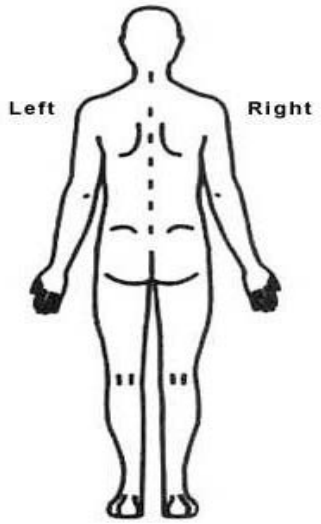
(PLEASE CIRCLE ALL THAT APPLY):

Cancer	Heart Disease	Diabetes	High Blood Pressure
Stroke	Multiple Sclerosis	Arthritis	Asthma

Other: _____

NAME:_____ **DOB:**_____/_____/_____

Briefly describe your symptoms: _____



MARK where it hurts: **Height:** _____ **Weight:** _____

Circle your level of pain/discomfort today: **None** 0 1 2 3 4 5 6 7 8 9 10 **Severe**

When did your symptoms begin? _____

How did your symptoms start?_____

How often do you experience your symptoms? Constantly Frequently Occasionally Intermittently

When are your symptoms worse? Morning Afternoon Evening Night

Are your symptoms: Improving Worsening Unchanged

What makes your condition better?

Ice Heat Activity Lying down Medication Rest Stretching other:_____

What makes your condition worse?

Activity Bending Lifting Standing Stress Twisting Sitting other:_____

Have you been to a Chiropractor before? No / Yes

Review of Systems:

What are your habits? (Please circle all that apply.)

Smoking:	**Never**	**Occasionally**	**Moderately**	**Excessively**
Alcohol:	**Never**	**Occasionally**	**Moderately**	**Excessively**
Exercise:	**Never**	**Occasionally**	**Moderately**	**Excessively**

Presently or within the past 6 months, suffered from any of the following?

1. **General:** Normal
   Chills recent weight loss or gain Lethargy/Weakness Recurring Fever Other_____
2. **Skin:** Normal
   Hives Rash Hair Change Psoriasis Nail Change Itching Other_____
3. **Neurologic:** Normal
   Migraines Dizziness Memory loss Poor balance Stroke Numbness
   Tingling Pins and needles Seizures Tremors Head injury Other_____
4. **Eyes:** Normal
   Vision Trouble Pain Discharge Other_____
5. **Ears/Nose/Throat:** Normal
   Hearing Trouble Pain Visual changes Discharge Ringing Sinus problems Nose bleeds Hearing loss
   Ear pain Sore throat Swollen glands Other_____
6. **Heart/Lungs:** Normal
   Pacemaker High blood pressure Heart attack High cholesterol Swollen Extremities Chest Pain
   Palpitations Blood clots Mitral valve prolapse Cough Asthma Shortness of breath
   Sleep apnea Other_____
7. **Stomach/Intestines:** Normal
   Vomiting Constipation Pain Diarrhea Decreased Appetite Ulcer Bloating/Cramping Heartburn
   Hepatitis Other_____
8. **Urination:** Normal
   Incontinence Frequent Urination Blood in urine Painful Urination Other_____
9. **Blood:** Normal
   Goiter Heat/Cold Intolerance Tremor Sugar in Urine Other_____
10. **Mental:** Normal
    Insomnia Depression Anxiety Difficulty concentrating Memory Loss
    Alzheimers disease Agitation/Irritability Suicidal thoughts Other_____
11. **Male:** Normal
    Sexually transmitted disease Testicular pain or lumps Prostate disease Other_____
12. **Female:** Normal
    Hot flashes Menopause Menstrual irregularity Loss of libido Sexually transmitted disease
    Breast lumps or pain Other_____