

CRUZ CHIROPRACTIC

"Making A Difference... One Life At A Time Since 1982"

Please Print: _____ **Date:** _____

Name: _____ **Date of Birth:** _____

Spouse: _____ **Date of Birth:** _____

Social Security Number: _____

Telephone: Home: _____ **Work:** _____ **Cell:** _____

Address: _____

E-Mail: _____

Married: ____, **Single:** ____, **Number of Children:** ____

Occupation: _____ **Where Employed:** _____

How Can We Help You? _____

When did it start? _____

How frequent does this occur: Constant ___ **On & Off** ___

Pain is Sharp ___ **Dull** ___ **Throbbing** ___

Do you have pain radiate into Hands or arms ___ **Legs or feet** ___ **other** ___

Have you ever had similar complaints? Yes ___ **No** ___

What activities aggravate your condition/pain? _____

Is condition worse during AM ___ **PM** ___

Is this condition getting progressively Worse ___ **about the same** ___ **Better** ___

Other Doctors seen for this condition _____

Any home remedies? _____

Other Symptoms:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pins & Needles in legs | <input type="checkbox"/> Fever |

What level is your pain: lowest 1 2 3 4 5 6 7 8 9 10 **highest**

Please circle what services you are interested in:

**Chiropractic, Laser therapy, Dietary lifestyles, Enzyme therapy,
Foot Scan/orthotics, Nutritional Consultation, Rehabilitation, Scar Tissue Release**

How committed are you to your health? ___not at all ___somewhat ___ very important

Payment Information

Do you have health insurance? Yes___ No___

PLEASE NOTE: The cost of your exam and x-rays are to be paid on the day of service. Please give the receptionist your insurance card so we can make a copy.

Will you be paying with: Cash___, Check___, Credit Card___, Debit Card___?

Please let us know who referred you to our office so we can be sure to thank them.

Females: Is there a chance you may be pregnant Yes___ No___

Please list all medications you take & for what reason.

_____	_____
_____	_____
_____	_____
_____	_____

After your first visit, you will be scheduled for a **Chiropractic Report** to discuss the different types of **Active Life Plans** that are available to you. **Chiropractic Life Plans** are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the **Chiropractic Active Life Plans** prior to your **Chiropractic Report** appointment so you can choose the level of participation that supports you in reaching all of your health goals.

Signature

Date