Date of Appointment ___________________________________

Name ___________________________________ Date of Birth___________________________________

Occupation______________________________ # Hours per week currently working______________

Phone Number ___________________________ Email ____

Address __________________________ City __________________State__________Zip_______________

Insurance Company____

What is your primary reason for visiting?____

Circle any of the following symptoms you have experienced in the past 30 days:

Pain/Tension/Numbness in:

Neck	Low Back	Arms	Hip(s)
Shoulders	Legs	Knee(s)	Headaches

Headaches/Migraines	Sinus/Allergies	Ringing in ears	Other:
Fatigue	Menstrual Problems	Nervousness	___________________
Insomnia	Asthma	Dizziness	___________________
Irritability	Stress/Anxiety	Weight Trouble	___________________
Digestive Trouble	Bladder Trouble		___________________
			___________________
			___________________

Which of the above bothers you the most?____

Thank you for filling this out! Please bring it to your complimentary consultation.