# MOBILE CHIROPRACTIC CARE OF NJ, LLC.

**Personal and Family Health History:**

Name_____ Date_____

Address _____ Referred By _____

City_____State _____Zip _____ Social Security #_____

Phone: (H)_____(W)_____ Occupation _____

E-mail_____(C) _____ Employer_____

Date of Birth _____Age_____ Marital Status S M D W

Spouse's Name_____ Spouse's Occupation _____

Children's Names & Ages _____

Hobbies or Recreation _____

**Current Health Condition**

Present Complaint (be brief) reason for your visit today

Major _____

Pain or Problem stated on _____

Pains are: _____Sharp ____Dull ____Constant ____Intermittent

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is condition worse during certain times of the day?_____

Is this condition interfering with Work?_____Sleep?____Routine? ____ Other?_____

Is this condition getting progressively worse?_____

Other doctors seen for the condition?_____

Any home remedies?_____

Rate the severity of your pain. (1 mild pain or discomfort to 10 severe pain): 1 2 3 4 5 6 7 8 9 10

**Other symptoms:**

| | | | |
|---|---|---|---|
| __Headaches | __Neck Pain | __Sleeping Problems | __Back Pain |
| __Nervousness | __Tension | __Irritability | __Chest Pains |
| __Dizziness | __Face Flushed | __Neck Stiff | __Fatigue |
| __Depression | __Ears Ring | __Fever | __Fainting |
| __Cold Sweats | __Loss of Smell | __Loss of Taste | __Diarrhea |
| __Feet Cold | __Hands Cold | __Stomach Upset | __Constipation |
| __Loss of Balance | __Buzzing in Ear | __Loss of Memory | __Light Bothers Eyes |
| __Shortness of Breath | __Numbness in Fingers | __Numbness in Toes | __Other |
| __Pins&Needles in Arms | __Pins&Needles in Hands | | |

Have you been under drug or medical care?_____

What medications are you taking?_____How long _____

Have you had surgery?_____What_____When_____

What side effects have you experienced from drugs or surgery?_____

(Women) Are you pregnant? __Yes __No. Nursing? __Yes __No. Birth controls pills? __Yes __No

| Is there a family history of: | Heart Disease | Arthritis | Cancer | Diabetes | Other |
|---|---|---|---|---|---|
| Father's Side | _____ | _____ | _____ | _____ | _____ |
| Mother's Side | _____ | _____ | _____ | _____ | _____ |

**The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.**

Patient or Guardian Signature:_____ Date _____