

Date: \_\_\_\_\_

Name \_\_\_\_\_ Sex: Male or Female

Married \_\_\_ Spouse name: \_\_\_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referred by \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever received Chiropractic Care?  Yes  No If yes, when & by who? \_\_\_\_\_

**1. Primary reasons and location for seeking chiropractic care:**

Primary reason: \_\_\_\_\_

Secondary reason: \_\_\_\_\_

Other factors contributing to the primary and secondary reasons: \_\_\_\_\_

Complaint Began when and how? \_\_\_\_\_

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

**3. Have you had previous treatments, medications, surgery, or care you've sought for these current complaints:**

\_\_\_\_\_  
\_\_\_\_\_

**4. Past Health History:**

A. Prior illnesses requiring hospitalization or treatment: \_\_\_\_\_

\_\_\_\_\_  
B. Previous injuries auto accidents, broken bones, etc.: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

C. Allergies to treatment: \_\_\_\_\_

D. Medications:  
Medications and reason for taking

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries:  
Type or surgeries and approximate date

\_\_\_\_\_  
\_\_\_\_\_

E. Females/ Are you pregnant or think you may be pregnant? YES or NO  
What was the date of the beginning of your last menstrual period? \_\_\_\_\_

5. Family Health History:  
Mother /Father health issues? \_\_\_\_\_

\_\_\_\_\_

6. Social and Occupational History:

A. Level of Education:

high school    some college    college graduate    post graduate studies

B. Job description: \_\_\_\_\_

C. Work schedule: \_\_\_\_\_

D. Recreational activities: \_\_\_\_\_

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize **Butler Chiropractic, 1501 Cross Timbers Rd., Flower Mound, Texas 75028** to provide me with chiropractic care, in accordance with Texas state statute.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Butler Chiropractic Clinic 1501 Cross Timbers Rd # 200, Flower Mound, Texas 75028

Patients Signature: \_\_\_\_\_

Please Circle the Appropriate Answer

- |   |     |    |
|---|-----|----|
| 1. Do you need glasses to read?                         | Yes | No |
| 2. Do you need glasses to see things at a distance?     | Yes | No |
| 3. Has your eyesight often blacked out completely?      | Yes | No |
| 4. Do you often have bad pains in your eyes?            | Yes | No |
| 5. Are your eyes often red or inflamed?                 | Yes | No |
| 6. Are you hard of hearing?                             | Yes | No |
| 7. Have you ever had fluid leaking from your ear?       | Yes | No |
| 8. Do you have constant noises in your ears?            | Yes | No |
| 9. Do you have to clear your throat constantly?         | Yes | No |
| 10. Do you often feel a choking lump in your throat?    | Yes | No |
| 11. Are you often troubled with bad spells of sneezing? | Yes | No |
| 12. Is your nose continually stuffed up?                | Yes | No |
| 13. Do you suffer from a constantly running nose?       | Yes | No |
| 14. Have you at times had bad nose bleeds?              | Yes | No |

Heart-Lung

- |  |     |    |
|--|-----|----|
| 15. Do you frequently suffer from heavy chest colds?                   | Yes | No |
| 16. Do you get hay fever?  | Yes | No |
| 17. Do you suffer from asthma?   | Yes | No |
| 18. Are you troubled by constant coughing?                             | Yes | No |
| 19. Have you ever coughed up blood?                                    | Yes | No |
| 20. Do you wake up drenched with sweat during the middle of the night? | Yes | No |
| 21. Have you ever had a chronic chest condition?                       | Yes | No |
| 22. Has a doctor ever said your blood pressure was too high?           | Yes | No |
| 23. Has a doctor ever said your blood pressure was too low?            | Yes | No |
| 24. Do you have pains in the heart or chest?                           | Yes | No |
| 25. Are you often bothered by thumping of the heart?                   | Yes | No |
| 26. Does your heart often race like mad?                               | Yes | No |
| 27. Do you often have difficulty breathing?                            | Yes | No |
| 28. Are your ankles often badly swollen?                               | Yes | No |
| 29. Do cold hands or feet trouble you, even in hot weather?            | Yes | No |
| 30. Do you suffer from frequent cramps in your legs?                   | Yes | No |
| 31. Has your doctor ever said you had heart trouble?                   | Yes | No |
| 32. Does heart trouble run in your family?                             | Yes | No |

Digestive System

- |  |     |    |
|--|-----|----|
| 33. Do severe pains in the stomach often cause you to double over? | Yes | No |
| 34. Do you suffer from constant stomach trouble?                   | Yes | No |
| 35. Does stomach trouble run in your family?                       | Yes | No |
| 36. Has a doctor ever said you had stomach ulcers?                 | Yes | No |
| 37. Do you suffer from frequent loose bowel movements?             | Yes | No |
| 38. Have you ever had severe bloody diarrhea?                      | Yes | No |
| 39. Do you constantly suffer from bad constipation?                | Yes | No |
| 40. Do you usually feel bloated after eating?                      | Yes | No |

**Musculoskeletal**

42. Are your joints often painfully swollen?	Yes	No
43. Do your muscles and joints constantly feel stiff?	Yes	No
44. Do you usually have severe pains in the arms or legs?	Yes	No
45. Are you crippled with severe arthritis?	Yes	No
46. Does arthritis run in your family?	Yes	No
47. Do weak or painful feet make your life miserable?	Yes	No
48. Do pains in the back make it hard for you to keep up with your work?	Yes	No
49. Are you troubled with a serious bodily disability or deformity?	Yes	No
50. Does pressure or pain in the head often make life miserable?	Yes	No
51. Are headaches common in your family?	Yes	No
52. Do you often have spells or severe dizziness?	Yes	No
53. Do you frequently feel faint?	Yes	No
54. Have you fainted more than twice in your life?	Yes	No
55. Do you have constant numbness or tingling in any part of your body?	Yes	No
56. Were you ever knocked unconscious?	Yes	No
57. Have you at times had a twitching of the head, face or shoulder?	Yes	No
58. Did you ever have a seizure or convulsion (epilepsy)?	Yes	No
59. Has anyone in your family ever had seizures or convulsions (epilepsy)?	Yes	No
60. Did a doctor ever treat you for a tumor or cancer?	Yes	No
61. Do you suffer from any chronic disease?	Yes	No

**Genito-Urinary**

62. Are you a sleep walker?	Yes	No
63. Are you a bed wetter?	Yes	No
64. Were you a bed wetter between the ages of 8 to 14?	Yes	No
65. Are you crippled with severe arthritis?	Yes	No
66. During the day, do you unusually have to urinate frequently?	Yes	No
67. Do you often have severe burning when you urinate?	Yes	No
68. Do you sometimes lose control of your bladder?	Yes	No
69. Has a doctor ever said you had kidney or bladder disease?	Yes	No

**Women Only**

70. Are you pregnant?	Yes	No
71. Have your menstrual periods usually been painful?	Yes	No
72. Have you often felt weak or sick with your periods?	Yes	No
73. Have you often had to lie down when your periods came on?	Yes	No
74. Have you usually been tense or jumpy with your periods?	Yes	No
75. Have you ever had severe hot flashes or sweats?	Yes	No
76. Have you often been troubled with a vaginal discharge?	Yes	No

**Men Only**

77. Have you ever had treatment for your genitals?	Yes	No
78. Have you ever passed blood while urinating?	Yes	No
79. Do you have trouble starting your stream when urinating?	Yes	No
80. Do you have to get up every night and urinate?	Yes	No

**Immune System**

81. Does working tire you out completely?	Yes	No
82. Do you usually get up tired or exhausted in the morning?	Yes	No
83. Does every little effort wear you out?	Yes	No
84. Do you suffer from severe nervous exhaustion?	Yes	No
85. Are you frequently confined to bed by illness?	Yes	No
86. Are you considered a sickly person?	Yes	No
87. Do severe pains and aches make it impossible for you to do your work?	Yes	No
88. Do you wear yourself out worrying about work?	Yes	No
89. Are you always ill and unhappy?	Yes	No

Patients Signature: \_\_\_\_\_

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