

Please print and fill out before first visit



Dr Jason Guben, Chiroprator, RN, DC



First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Age \_\_\_\_\_ Sex m  f

Address \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_

Postal Code \_\_\_\_\_ Tel (res) \_\_\_\_\_

Tel (office) \_\_\_\_\_ ext \_\_\_\_\_ Tel (cell) \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_\_\_ Occupation \_\_\_\_\_

Email \_\_\_\_\_

Civil Status \_\_\_\_\_ Spouse's name \_\_\_\_\_

Who recommended you to our office? Friend  Outside Sign  Spouse   
Other  Name \_\_\_\_\_

Have you ever seen a chiropractor? Yes  No   
Who \_\_\_\_\_  
When \_\_\_\_\_

Do you have insurance that covers chiropractic care? Yes  No

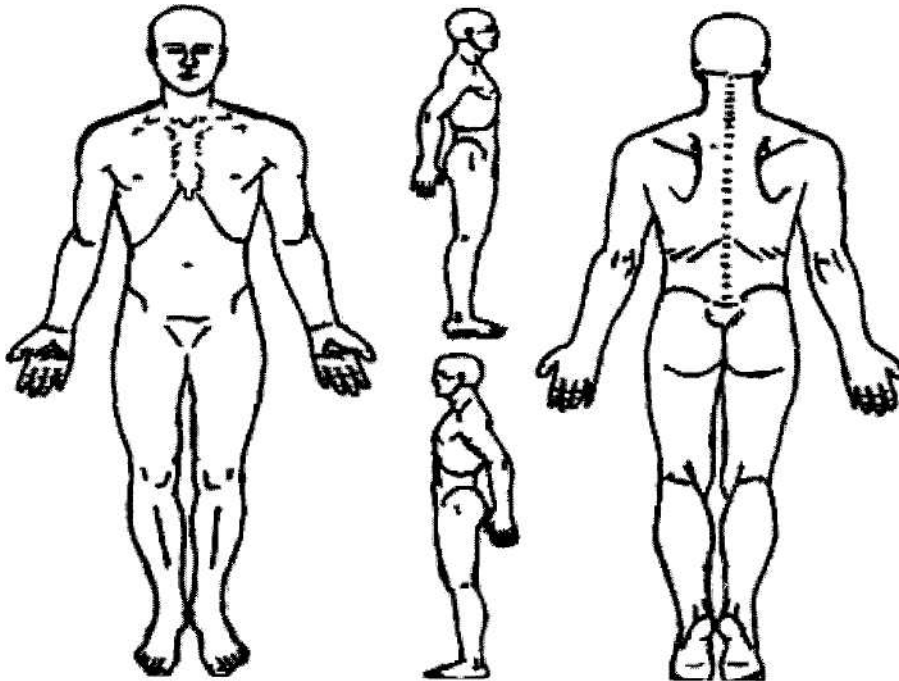
Family Doctor \_\_\_\_\_  
Doctor's address \_\_\_\_\_

Date of Last Physical Examination (mm/dd/yy) \_\_\_\_\_

Please indicate on the drawing, the exact location of your problems.

Numbness ••••  
 Pins + Needles \* \* \* \*  
 Stabbing-Sharp ///

Burning xxxx  
 Stiff + Tight 2222  
 Aching +++



What is the reason for your consultation? Please list your health problems in order of importance

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1. Check the box that indicates the severity of your main problem.

**USUAL LEVEL OF PAIN**

No Pain Extreme pain

1   2   3   4   5   6   7   8   9   10

**PRESENT LEVEL OF PAIN**

No Pain Extreme pain

1   2   3   4   5   6   7   8   9   10

**2. Are you currently taking any medication on a regular basis?** Yes  No

If Yes, What: (Coumadine, Heparin, Plavix, Aspirin, Antihypertensive etc).

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**3. Have you ever had any of the following conditions:**

- Aneurysm  Osteoporosis  Diabetes   
Cancer  Migraines  Headaches   
Fatigue  Asthma  Arthritis   
Psoriasis  Dizziness  Weight Loss   
Hypertension  Stroke   
Epilepsy  Nervous System Disorder   
Gout  Respiratory Problems   
Insomnia  Heart Conditions   
Depression  Rheumatoid Arthritis   
Convulsions  Sinus Problems   
Tingling  Loss of Consciousness

**4. Have you ever had any fractures?** Yes  No

**5. Have you ever been in a car accident?**

Yes  No  \_\_\_\_\_

**6. Have you ever been hospitalised?** Yes  No

**7. Do you smoke?** Yes  No

**8. Have you smoked in the past?** Yes  No

**9. When** \_\_\_\_\_

**9. Do you have any allergies?** Yes  No  If yes, to what \_\_\_\_\_

**10. Have you ever been on birth control pills?**

Currently / Previously / Never

**11 # Of Pregnancies** \_\_\_\_\_ **# Of Children** \_\_\_\_\_