



# INTEGRAL CHIROPRACTIC CENTER

## Client Information

Name:		Phone: (h)				Date:	
Address:		Phone: (w)				Sex:	
City, State & ZIP:		Phone: (c)				Birthday:	
Email:		Fax:				Marital Status:	
SS#:	Employer:	Occupation:		Height:	Weight:		
Name and phone number of emergency contact:				Referred By:			
Reason for seeking care:				Result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
When did it start?		<input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually		Getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What brought it on?		Frequency:		What makes it worse?		What makes it better?	
Severity:							
Mild							Severe
1	2	3	4	5	6	7	8 9 1 0
Does it interfere with your daily activities?							
Not at all							All of the time
1	2	3	4	5	6	7	8 9 1 0
When was your first visit to a chiropractor?				When was your last visit to a chiropractor?			
Other doctors seen for this problem:				Do other family members suffer from a similar problem? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? How long?			
Office Use Only: <input type="checkbox"/> File <input type="checkbox"/> TC <input type="checkbox"/> Medisoft <input type="checkbox"/> QC <input type="checkbox"/> EN <input type="checkbox"/> WL <input type="checkbox"/> ROF 1 2 3 4 <input type="checkbox"/> HCC							