SCHIFFMAN CHIROPRACTIC
DR. ROBERT. R. SCHIFFMAN, DC, FICA

Please print clearly and fill in completely

Print Name _____ **Email** _____

Street Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____ **Date of Birth** _____

Health History

Give reason for seeking chiropractic care: _____

Additional details about this issue: _____

Describe any other health problems, including how long you've had them: _____

_____

Are you under the care of any other doctor? Yes❑ No❑ If Yes, explain conditions being treated for:

_____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History

Your Occupation _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes, Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ If yes why? _____

Rate Your Overall Health

Our goal is to help you achieve and maintain optimal health. To better help you with this we need to understand how you view your overall health. Please **circle** what you consider to be your current level of health.

10%-------- 20% --------30%-------- 40% --------50%-------- 60% --------70%-------- 80% --------90% ------- 100%

Referrals

Our clinic is primarily referral based. We would like to know who we can thank for sending you to us. Please let us know who referred you, ***or*** where you heard about our clinic? _____

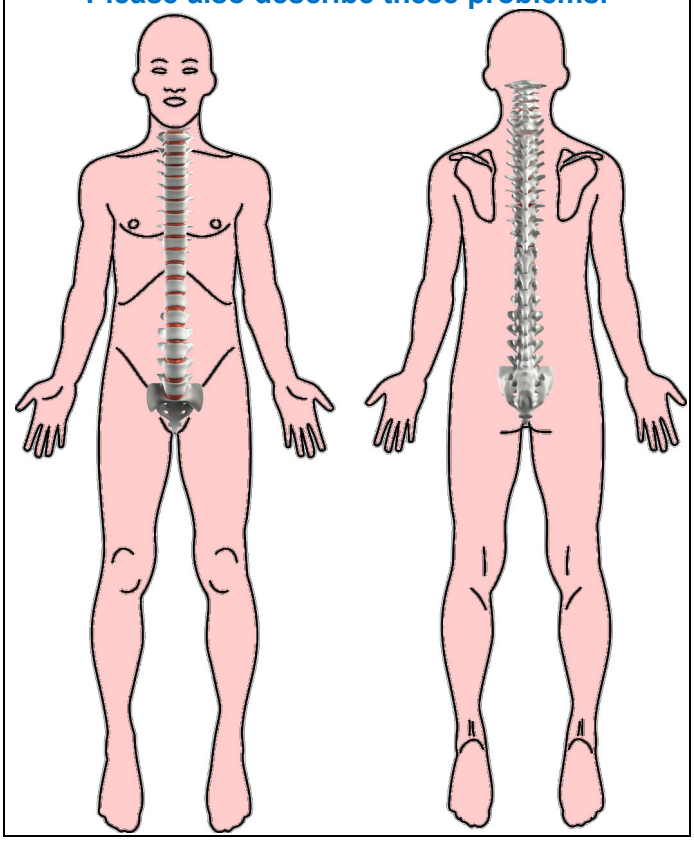
FEMALES ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes ❑** **No ❑**

Please Fill in Below

If you currently or recently have suffered from the following, *please check if YES* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg / Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Joint Pain / Swelling	❑	❑
Numbness	❑	❑
Frequent Colds	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Anxiety / Depression	❑	❑
Sleep Disorders	❑	❑
Heart Problems	❑	❑
High Blood Pressure	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Asthma	❑	❑
Allergies	❑	❑
Female Issues	❑	❑
Cancer	❑	❑
Hypoglycemia	❑	❑
Diabetes	❑	❑
Osteoporosis	❑	❑
Digestive Problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other: Write in:	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Please use the space below to fill in any additional health information you feel we may need for your care.

_____

_____

_____

_____

_____

_____

_____

_____

Your Signature Below Please

_____

Date: _____