



# WINTERS CHIROPRACTIC CENTER

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_ Would you like information via email? Y/N

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN.

\_\_\_\_\_

DATE PROBLEM BEGAN: \_\_\_\_\_  
 Is this: Work Related \_\_\_\_\_ Auto Related \_\_\_\_\_ N/A \_\_\_\_\_

How you feel today  
 [0 1 2 3 4 5 6 7 8 9 10]  
 No Pain \_\_\_\_\_ Unbearable Pain \_\_\_\_\_

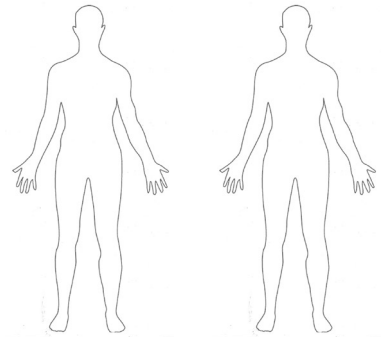
How often are your symptoms present?  
 0-25% \_\_\_\_\_ 26-50% \_\_\_\_\_ 51-75% \_\_\_\_\_ 76-100% \_\_\_\_\_

Can you perform your daily activities? Yes \_\_\_\_\_ No \_\_\_\_\_ (Describe) \_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? Y \_\_\_\_\_ (DATE \_\_\_\_\_) N \_\_\_\_\_  
 WHAT AREAS WERE TAKEN? \_\_\_\_\_

MARK AN X ON THE PICTURE  
 WHERE YOU HAVE PAIN  
 (Front) (Back)



PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU:

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	History of Recent Infection	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy (# of births _____)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain
<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid Use	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (DATE _____)	<input type="checkbox"/>	<input type="checkbox"/>	Low/Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in Groin/Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries/Medications: _____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis			_____
<input type="checkbox"/>	<input type="checkbox"/>	Trauma			_____

Family History: Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Cardiovascular Problems/Stroke \_\_\_\_\_

I certify that the above information is complete and accurate. If the health plan information is no accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify Dr. Winters immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_