Stewart Chiropractic Clinic, Dr. Shane D. Stewart (803)648-0189

To best serve you, please fill in all information requested below.

1. Name _____ 2. Sex M F 3. S.S. # ____-____-_____

4. Address (Street, City, State, Zip) _____

5. Home Phone _____ 6. Work Phone _____ 7. Date of Birth _____ 8. Age____

9. Marital Status (circle one) M S W D 10. No. of children ____ 11. Spouse's name_____

12. Occupation/employer_____ 13. Referred By_____

14. Is your insurance in your name? Y, N , 15. Birthday of Spouse_____

***** If this condition is due to an auto accident or work related injury, please inform us now. *****

16, What is your primary complaint? _____

A. Is this your first time to experience this condition? _____

B. Date you noticed it this time _____

C. What activity or injury caused this condition? _____

D. If you have pain, is the pain ____stabbing?, ____ a dull ache?, ____ throbbing?

E. Is there any numbness, tingling, or burning yet? _____

F. Is this condition ____ constant and unrelenting?, or does it ____come and go?

G. What seems to reduce the pain? _____H. What makes the condition worse? _____

I. Have you received other care for this condition? _____ If yes, whom did you consult?_____

J. List any secondary complaints you may have.

_____

17. Have you had chiropractic care before? _____ If yes, when and where? _____

18. Have you ever had any auto accidents, falls, or other injuries?

month/ year type of accident describe injury

_____

_____

19. List any surgeries you may have had.

month/ year type of surgery comments

_____

_____

20. List any medications you are taking and for what conditions.

_____

21. Please check any of the following that give you difficulty.

___Headaches	___Pain in legs and feet	___Heart attacks	___Numbness
___Neck Pain	___Ringing in ears	___Fainting	___Constipation
___Sinus trouble	___Blurred Vision	___Chest Pains	___Kidney trouble
___Allergies	___Light bothers eyes	___Anemia	___Menstrual cramps
___Hayfever	___Shooting head pain	___Stomach troubles	___Cramps
___Low Back Pain	___Muscle spasms in neck	___Nervousness	___Diabetes
___Mid-back pain	___Grating in neck	___Inner tension	___Cancer
___Thyroid trouble	___Tight shoulder muscles	___Irritability	___Sleeping problems
___Twitching of face	___Pain in shoulders & arms	___Cold sweats	___Painful joints
___Loss of memory	___Pins & needles in arms	___Gall bladder trouble	___Swollen joints
___Fatigue	___Shortness of breath	___Indigestion	___Pinched nerves
___Inflamed throat	___Numbness in hands	___Intestinal gas	___Pins and needles
___Dizziness	___Low Blood Pressure	___Asthma	___Swollen ankles
___Loss of Balance	___High Blood Pressure	___Depression	___Cold feet

I consent to the treatment necessary for the above named patient. I agree that I am responsible for any balance not paid by insurance. I authorize insurance to be filed according to HCFA -1500 requirements .

22. Date/signature: _____