Crossroads Chiropractic
2826 Moody Parkway Ste A
Moody, AL 35004
(205)640-6500

Full Name_____ Today's Date_____
Mailing Address_____
City_____ State____ Zip_____
Street address, if different_____
City_____ State____ Zip_____
Home phone (include area code)_____ Business phone_____
Age___ Date of birth_____ Sex____ Marital Status___ SS#_____
Occupation_____ Religious affiliation_____
I was referred by_____
Reason for referral_____
Nearest friend or relative_____ Phone_____
Mailing address_____
City_____ State____ Zip_____

Give the following information about your immediate families health:

Relationship	Age if living	Age at death	State of health or cause of death
Father	____	____	_____
Mother	____	____	_____
Brothers & sisters	____	____	_____
	____	____	_____
	____	____	_____
	____	____	_____
Spouse	____	____	_____
Children	____	____	_____
	____	____	_____
	____	____	_____
	____	____	_____

Have any of your blood relatives had any of the illnesses listed below? If so, indicate relationship (father, sister, etc.).

Illness	family member
Asthma	_____
Tuberculosis	_____
High blood pressure	_____
Heart disease	_____
Stroke	_____
Diabetes	_____
Cancer	_____
Blood disease	_____
Glaucoma	_____
Rheumatoid arthritis	_____
Gout	_____
Rheumatic fever	_____

Illness	family member
Epilepsy	_____
Mental problems	_____
Suicide	_____
Alcoholism	_____

List all surgery, hospitalizations and serious injuries you have had:

year	surgery, illness or injury	hospital and city
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____

Please check any of the following illnesses and disorders you have or have had and indicate the approximate year when each started.

	(X)	Year
Eye or eyelid infection	___	____
Glaucoma	___	____
Other eye problems	___	____
Ringing in the ears	___	____
Deafness or poor hearing	___	____
Other ear problems	___	____
Headaches	___	____
Head injury	___	____
Stroke	___	____
Convulsions or seizures	___	____
Allergies, asthma, hay fever	___	____
Strep throat	___	____
Bronchitis	___	____
Pneumonia	___	____
Tuberculosis	___	____
Emphysema	___	____
Other lung problems	___	____
High blood pressure	___	____
Heart attack	___	____
Heart murmur	___	____
High cholesterol	___	____
Arteriosclerosis	___	____
Other heart condition	___	____
Thyroid disorder	___	____
Diabetes	___	____

Stomach or duodenal ulcer	___	____
Colitis	___	____
Diverticulosis	___	____
Other bowel problems	___	____
Hemorrhoids	___	____
Hepatitis	___	____
Other liver problems	___	____
Gall bladder problems	___	____
Hernia	___	____
Kidney or bladder problems	___	____
Prostate problems	___	____
Arthritis	___	____
Gout	___	____
Cancer or tumor	___	____
Bleeding tendency	___	____
Measles/rubeola	___	____
German measles/rubella	___	____
Scarlet fever	___	____
Chicken pox	___	____
Mumps	___	____
Polio	___	____
Mononucleosis	___	____
Eczema	___	____
Psoriasis	___	____
Venereal disease	___	____
Other.....	___	____

Please explain:_____

List the current problems, which are of the most concern to you.

Date began	Problem
_____	_____
_____	_____
_____	_____

List any disorders for which, you are being treated for, by another health care practitioner.

Illness or disorder	Practitioners name	City
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medications you are now taking, including non-prescription drugs and nutritional supplements.

List items to which you are allergic (e.g., foods, medications, penicillin, bee stings, pollens, dust, chemicals, soaps, etc.) and indicate how each item affects you.

Fill in the years in which you had the following inoculations:

Tetanus_____ Measles_____ Mumps_____
Polio _____ Typhoid_____ Influenza_____
Other _____

Have you traveled in a foreign country in the last 20 years?.....no_____ yes_____

Traveled in	Date(s)
_____	_____
_____	_____
_____	_____

Have you had a tuberculin (TB) skin test?.....no_____yes_____

If so, the date of the test was _____ and the result was: negative____ positive____

	No	Yes
Have you ever worked or spent time:.....on a farm?	___	___
in a laundry or mill?	___	___
in a very dusty place?	___	___
In a mine?	___	___
with or near toxic chemicals?	___	___
with or near radioactive chemicals?	___	___
with or near asbestos?	___	___

Have you recently had any changes in your: (if yes, please explain on line to left.)

.....Marital status?	___	___
.....job or work?	___	___
.....financial status?	___	___
.....residence?	___	___
.....Are you having any legal problems?	___	___

What is your weight now? _____lbs.
What is your height now? _____ft. _____in.

How is your general health now?.....good____ fair____ poor____
How has your health been most of your life?.....good____ fair____ poor____

In the past year:...has your appetite changed? Stayed same____ increased____
decreased____

has your weight changed? No change ____ gained___lb.
lost___lb.

are you often noticeably thirsty? No____ yes___
has your general energy level changed? Stayed same____ increased____
decreased____

	rarely/ never	sometimes	often
Do you:.....become tired easily?	____	____	____
feel depressed?	____	____	____
feel bored most of the time?	____	____	____
have trouble making decisions?	____	____	____
worry a lot?	____	____	____
have trouble relaxing?	____	____	____
become angry easily?	____	____	____
have sexual problems?	____	____	____
ever feel like committing suicide?	____	____	____
use marijuana?	____	____	____
use hard drugs?	____	____	____

	no	yes
Do you often feel tired?	___	___
Have you ever fainted or felt like fainting?	___	___
Do you get cold hands or feet easily?	___	___
Do you sweat easily?	___	___
Do you often have difficulty sleeping?	___	___
Do you often sleep restlessly?	___	___
Does any part of your body get numb?	___	___
Do you ever have fits or convulsions?	___	___
Do you ever shake or tremble?	___	___
Do you ever have any problem with coordination?	___	___
In the last 3 months have you had: a fever lasting more than a day?	___	___
any cold sores (fever blisters)?	___	___
sores or cuts that were hard to heal?	___	___
any lumps in your neck, armpit or groin?	___	___
chills or sweating at night?	___	___
Do you have:.....dry skin?	___	___
brittle fingernails?	___	___
any moles that have changed in color or in size?	___	___
any other skin problems?	___	___
do you bruise easily?	___	___

	rarely/ never	sometimes	often
In the past year have you had:.....feelings of nervousness?	____	____	____
shoulder pain?	____	____	____
back pain?	____	____	____
muscle or joint stiffness or pain due to sports, exercise or injury?	____	____	____
pain or swelling in any joints not due to sports, exercise or injury?	____	____	____

	no	yes
Do you wear eyeglasses?	___	___
Do you wear contact lenses?	___	___
Has your vision changed in the last year?	___	___

In the past year:	rarely/ never	sometimes	often
How often do you have:.....double vision?	____	____	____
blurry vision?	____	____	____
watery or itchy eyes?	____	____	____
Do you:...ever see colored rings around lights?	____	____	____
have difficulty hearing?	____	____	____
ever have ringing in your ears?	____	____	____
ever feel dizzy or experience motion sickness?	____	____	____
have trouble keeping your balance?	____	____	____
have any discharge from your ears?	____	____	____
How often do you have:.....headaches?	____	____	____
neck pains?	____	____	____
How often do you have.....head colds?	____	____	____
chest colds?	____	____	____
runny nose?	____	____	____
stuffed up nose?	____	____	____
sneezing spells?	____	____	____
nose bleeds?	____	____	____
sore or hoarse throat?	____	____	____
coughing spells?	____	____	____
trouble breathing?	____	____	____
coughing spells?	____	____	____
trouble breathing?	____	____	____
coughing up blood?	____	____	____
earaches?	____	____	____
Do you get short of breath when physically active?	____	____	____
Do you sometimes feel light headed or dizzy?	____	____	____
Have you ever fainted or passed out?	____	____	____
Does your heart ever feel like it is racing or beating to fast?	____	____	____
When you exercise do you get pains in your chest or shoulder?	____	____	____
Do you have cramps or pain in your thighs or legs when walking?	____	____	____
Do you need to sit up at night to breathe more easily?	____	____	____
Do you use several pillows at night to help you breathe more easily?	____	____	____
Do your legs cramp up at night?	____	____	____
Do you have swollen ankles or feet?	____	____	____

	rarely/ never	sometimes	often
How often, if ever.....are you nauseated?	____	____	____
Do you belch a lot after eating?	____	____	____
Do you have heartburn?	____	____	____
Do you have stomach pains?	____	____	____
Is it difficult for you to swallow your food?	____	____	____
Have you vomited blood?	____	____	____
Are you constipated?	____	____	____
Do you have diarrhea?	____	____	____
Are your bowel movements painful?	____	____	____
Do you have difficulty beginning to urinate?	____	____	____
Is urination painful?	____	____	____
Do you have to urinate more than [5 times if you are male, 8 times if female] per day?	____	____	____
Do you get up at night to urinate?	____	____	____
Do your ever lose urinate when you laugh, cough, sneeze, or strain hard?	____	____	____
Has your urine ever been bloody or dark colored?	____	____	____
Has your urine ever been cloudy or milky in appearance?	____	____	____

	no	yes
Do you have problems with your:.....teeth?	___	___
gums, jaw, or roof of mouth?	___	___
tongue, or taste sense?	___	___
Have you ever had a sigmoidoscopy?.....	___	___

Females only.....

What is the typical number of days between your menstrual periods?

Minimum is _____ days; Maximum is _____ days

	rarely/ never	sometimes	often
Are they accompanies by:.....pain and cramping?	____	____	____
nausea?	____	____	____
heavy bleeding or menstrual flow lasting longer than 4 days?	____	____	____
depression or irritability?	____	____	____
Do you experience:...swelling and edema prior to menstruating?	____	____	____
Bleeding between periods?	____	____	____
Pain on intercourse or sexual activity?	____	____	____
Vaginal irritation or discharge?	____	____	____
Do you ever have:...breast sensitivity?	____	____	____

Do you perform regular breast exams?.....yes ____ no ____

Date of: last gynecological exam_____ last pap smear_____

Name of gynecologist_____

List dates and ages when you have used birth control pills or an IUD:

	no	yes
Males only:.....Do you have prostate trouble?	___	___
Do you have any sexual problems or impotency?	___	___
Have you ever had sores or lesions on your penis?	___	___
Have you ever had discharge from your penis?	___	___
Do you ever have pain, lumps or swelling in your testicle?	___	___

How much do you exercise? All I need ___ less than I need ___ little or none ___
What specific types of exercise do you do? _____

_____

_____

Do you smoke now?.....no___ yes___
If yes, how many years _____
How many each day?___cigarettes ___cigars ___pipe-fulls ___chewing tobacco
Have you ever smoked?.....no___ yes___
If yes, how many years?_____
How many each day? cigarettes cigars pipe-fulls chewing tobacco
Have you ever tried to quit before? never ___ yes ___
How many times? _____
How long each time? 1. _____ 2. _____ 3. _____
Why did you begin smoking again? desire _____, nervous_____,
weight gain_____, no reason_____ other_____

Do you drink alcoholic beverages?.....no___ yes___
Per day, I drink: ___ beers ___glasses of wine ___drinks of hard liquor
Have you ever had a problem with alcohol?.....no___ yes___

Do you drink coffee or tea (do not include herbal teas)?.....no___ yes___
Per day, I drink____cups

NURTITION and DIET
How many meals do you eat each day? _____meals
Do you usually eat breakfast?..... no___ yes___
Do you diet frequently?.....no___ yes___
Are you dieting now?..... no___ yes___
Do you consider yourself: ___ just right ___overweight ___underweight

Do you snack?.....___rarely ___daily ___more than once a day

Do you add salt to your food at the table? ___ rarely ___sometimes ___ frequently

Check the frequency you eat the following kinds of foods

	More than once daily	daily	3 times weekly	once weekly	rarely or never
Whole grain cereal or bread	_____	_____	_____	_____	_____
Startches (pasta, white bread, etc)	_____	_____	_____	_____	_____
Sugar, desserts	_____	_____	_____	_____	_____
Dairy products	_____	_____	_____	_____	_____
Eggs	_____	_____	_____	_____	_____
Fresh meat, poultry, fish	_____	_____	_____	_____	_____
Smoked or processed meat	_____	_____	_____	_____	_____
Beans, peas	_____	_____	_____	_____	_____
Nuts and seeds	_____	_____	_____	_____	_____
Citrus fruit or juice	_____	_____	_____	_____	_____
Other fruit or juice	_____	_____	_____	_____	_____
Dark green, deep yellow & orange vegetables	_____	_____	_____	_____	_____
vinegar, pickled foods	_____	_____	_____	_____	_____

Additional problems you wish to discuss:

_____

_____

_____

_____

_____

Client's signature:_____