GROSKOPP
CHIROPRACTIC

Name__________________________ Date______________ ☐ Female ☐ Male

What name you prefer to be called____________________ Age_____ Date of birth______________

Home Address____

Preferred Language ☐ English ☐ Other __________ Race: ☐ White ☐ African American ☐ Other__________

Phone Number ____________________ Email Address ______________________________

Employer__________________Occupation________________ Work Phone______________

Emergency Contact ____________________ Relation____________ Phone______________

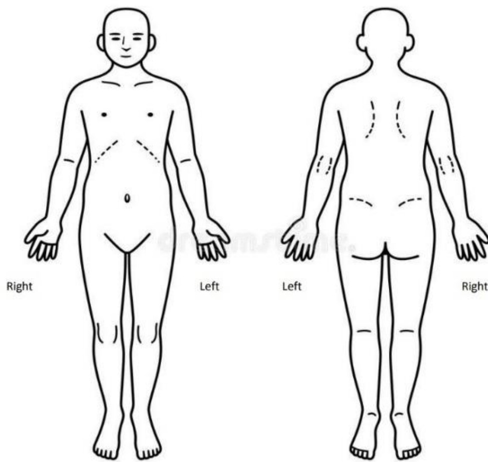
How did you hear about our office? ____

Is this injury related to a **work injury** or an **auto accident?** (Circle one) Date of injury__________________

When did your condition begin? ____________ Previous treatment for this condition? ☐ Yes ☐ No

Have you had the same or similar symptoms? ☐ Yes ☐ No Date of prior condition__________________

Mark Areas of Pain on Figures Below



List symptoms in order of severity:

(1)____

(2)____

(3)____

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physician______________________________

Current Medications___________________________

____

____

____

Allergies (Medicine, Food, Environmental) ____________

____

Previous Surgeries____

Do you have a **PERSONAL** history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Other serious illnesses____

Check all symptoms that apply to you:

☐ Headache	☐ Tingling/numbness in arm/hands	☐ Chest Pain	☐Unexplained weight loss
☐ Neck pain/stiffness	☐ Tingling/numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back pain/stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐Shoulder pain	☐ Shortness of breath	☐ Fever	☐ Blood in urine
☐ Other______________________________		☐ Night Pain	☐ Pain unrelieved by rest

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No