

Name _____	Birth Date _____
Cell Phone _____	Email Address _____
Occupation _____	
Home Address _____	City _____
Zip _____	
Who referred you to our office? _____	
Emergency Contact Name _____	Cell Phone _____
Relationship _____	

### Reason for the Visit

Sports Injury [ ] Auto Accident [ ] Other Injury [ ] Aging [ ] Get or Stay Healthy [ ]

Please list all the symptoms you are currently having or those that you wish to address with us and mark them on the picture below.

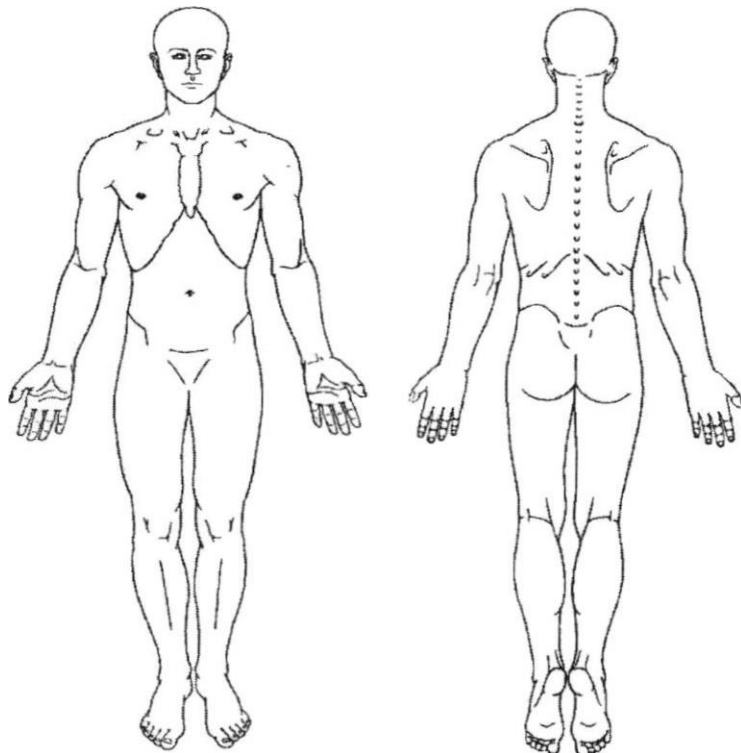
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When did these symptoms first start? \_\_\_\_\_

Do they interfere with: Work [ ] Sleep [ ] Exercise [ ] Daily Routine or chores [ ]

Are your symptoms Constant [ ] They come and go [ ] Activity activated [ ]

List the intensity of your symptoms: (0-1-2-3-4-5-6-7-8-9-10) 10 is the worst

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Please list all medications or supplements you're currently taking or ones that you were prescribed but you were unable to tolerate or may have caused your symptoms.

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Please indicate which of these apply to you:

Eat fast food [ ] Work long hours [ ] Headaches [ ] Experience gas/Bloating/indigestion [ ]  
High Stress [ ] Diabetes in your family [ ] Drink Diet sodas [ ] Fatty Liver [ ] Alcohol Daily [ ]  
Struggle with weight loss [ ] Lack of protein in diet [ ] High cholesterol [ ] Fatigue [ ]  
Muscle cramps [ ] Weak /Hair/Nails/Skin [ ] Tooth decay [ ] Family history heart disease [ ]  
Wake every night to urinate [ ] Family history of colds/Flus/infections/Poor immune system [ ]  
TMJ issues [ ] Poor gum health/Gingivitis [ ] Struggle with eating healthy throughout the day [ ]  
What type of exercise are involved with? \_\_\_\_\_

Other Health History :

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Now that you had the chance to review all of the symptoms that may have brought you here, please list any other things in your life that may have created these health issues. \_\_\_\_\_

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**Initial Analysis / Examination**

As a part of the analysis and examination process, you are consenting to the following examination procedures: Postural analysis and balance testing, range of motion, palpation, neurological testing, muscle strength testing and orthopedic testing.

**HIPAA acknowledgment**

No information regarding our patients is shared or distributed with any other person or organization without the patient's signed authorization. Your signature below acknowledges receipt of our privacy policy information statement.

**Patient's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dr. Jason Kelberman, DC** \_\_\_\_\_