MEEKER CHIROPRACTIC
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Non-Accident Form

Patient Name: _____ Today's Date: ____/____/____

General Information Related to the Condition:

□ No particular condition or symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment: _____

_____

_____

Approximately when did the conditions or symptoms begin to occur? ____/____/____

Additional Information Related to the Condition:

Describe your pain: □ Burning □ Sharp □ Dull □ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? □ Yes □ No When? ____/____/____

Describe: _____

_____

_____

_____

Please indicate any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	____/____/____
_____	_____	____/____/____

Please check any of the following symptoms you are **now** experiencing:

□ Headache	□ Dizziness	□ Light Bothers Eyes	□ Diarrhea	□ Head seems too heavy	□ Neck Pain
□ Loss of Memory	□ Clumsiness	□ Feet Cold	□ Neck Stiff	□ Tingling in arms/hands	□ Ears Ring
□ Hands Cold	□ Sleeping Problems	□ Tingling in legs/feet	□ Face Flushed	□ Difficulty swallowing	□ Back Pain
□ Numbness in arms/hands	□ Buzzing in Ears	□ Constipation	□ Nervousness	□ Numbness in legs/feet	□ Loss of Balance
□ Cold Sweats	□ Tension	□ Shortness of Breath	□ Fainting	□ Fever	□ Fatigue
□ Irritability	□ Loss of Smell	□ Chest pain/rib pain	□ Pain in arms/hands	□ Pain in legs/feet	□ Jaw pain
□ Loss of strength - arms	□ Burning muscle pain	□ Loss of strength - legs	□ Sharp/shooting pain	□ Nausea	

Other _____

_____

_____

Have you experienced changes to:

□ Eyes (sight) □ Ears (hearing) □ Nose (smell) □ Mouth (taste) □ Bladder

□ Bowels □ Sleep □ Emotion □ Appetite

Please Explain: _____

Have you missed work or school due to your injuries? □ Yes □ No

Do you smoke? □ Yes □ No Number per day: _____

Do you drink alcohol? □ Yes □ No Number per day: _____

Describe your eating habits: □ Poor □ Fair □ Good □ Excellent

Do you consume caffeine? □ Yes □ No If yes, how many cups per day? _____

Medical History:

Have you ever been in our office before? □ Yes □ No

Height: _____ Weight: _____

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ____/____/____

2) _____ ____/____/____

3) _____ ____/____/____

Date of last physical examination: ____/____/____

Serious illnesses or conditions: _____ When: ____/____/____

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Medications (please list all): _____

Do you now or have you ever had:

□ Heart Disease/Trouble	□ Diabetes	□ Cancer	□ Stroke	□ High Blood Pressure	□ Thyroid Problems
□ Tuberculosis	□ Prostate Disorder	□ Kidney Problems	□ Asthma	□ Ulcer	□ Seizure Disorder
□ Dizziness	□ Backaches	□ Hernia	□ Arthritis	□ Headaches	□ Numbness
□ Neuritis	□ Digestive Disorders	□ Nervousness	□ Sinus Trouble	□ Anemia	□ Depression

Other: _____

Family History:

Do you have any siblings? □ Yes □ No Are there any major medical problems (past or present) that are part of your siblings' history? □ Yes □ No
If yes, please describe: _____

Are your parents still living? □ Yes □ No Are there any major medical problems (past or present) that are part of your parents' history? □ Yes □ No
If yes, please describe: _____

Do your maternal/paternal grandparents have any major medical problems (past or present) that are part of their history? □ Yes □ No
If yes, please describe: _____

Patient Signature: _____ Date: ___/____/____