Suncrest Chiropractic
Where health and wellness align

Last Name:_____First Name:_____

Address:_____Birthday:_____

City/State:_____Zipe Code:_____

Email:_____

Cell:_____Home:_____

Emergency Contact:_____Phone:_____

Type of Employment:_____Hours Per Day/Week:_____

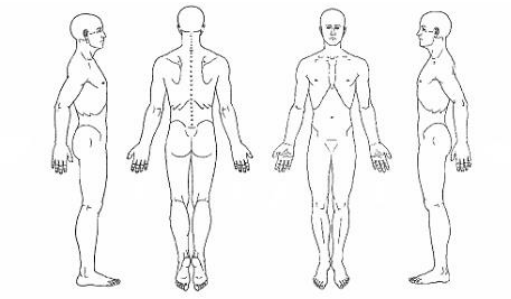
Medical Information: (Circle if they apply)

Allergies to Oils/Lotions	Broken Bones	Arthritis
Scoliosis	Heart Condition	High/Low Blood Pressure
Impetigo	Contact Lenses	Skin Condition
Bursitis	Diabetes	Stroke
Infectious Disease	Cancer	Pregnant
Migraine	Seizure	Varicose Veins
Skin Disorder(s)	Epilepsy	

Recent Surgeries:_____Prescriptions:_____

Primary Physician_____Phone:_____

Please mark where you experience pain



What Type of Pain?

Pinching Aching
Tingling Radiating
Numbness

What aggravates the pain?

_____

What relieves the pain?

_____

Have you been in an accident in the past year? YES NO

What other things have you tried to resolve your condition?

Physical Therapy Personal Training Chiropractic Medical Doctor
Acupuncture Cold Laser Infrared Sauna Massage Other_____

Signature:_____Date:_____