McMullen Chiropractic Clinic* 3801 West Waco Dr. / Waco, Tx 76710 1 / 2

ENTRANCE RECORD: Please print or write legibly as we need all the facts about your health before we accept you as a patient. Your information will be kept confidential.

Name:	Birth date: /	/ Sex: M / F	Date:	
Parent or Guardian - if patient is a m	inor;	Relations	Relationship:	
Address:	City:	State:	Zip:	
Phone Numbers: cell	home	work		
YOUR EMAIL:				
Occupation:	Retired / Unemployed *** Emp	loyer's name:		
Job duties:		Number of	monthsyears:	
Married / Single / Divorced / Widow	*** Spouse's name:			
Previous Chiropractic: Yes / No ***	Where:		When:	
Family doctor:	Which clinic	office?		
EMERGENCY CONTACT: name		phone number:		
**********	**********	*******	******	
Present complaint/symptom(s)				
When did your symptoms start? (<u>If filing</u>				
			·	
How did they start? UNKOWN				
Have you seen anyone else for your syn				
List any operations you have had and w				
List any broken / fractured bones: NON	E /			
Are you presently taking ANY PRESC	CRIPTION MEDICATION? YES /	NO * What are you	taking them for?	
Do you have or have you had? - HIGH	BLOOD PRESSURE - yes no ** DIA			
CANCER - yes no HEART ISSUES - ye	s no ** ARTHRITIS - yes no ** (OSTEOPOROSIS - yes	no ** DIZZINESS - yes no	

MCMULLEN CHIROPRACTIC CLINIC

Patient:	t: Date:	2/2
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PLEASE ANSWER THESE QUESTIONS BY CIRCLING YOUR RESPONSES

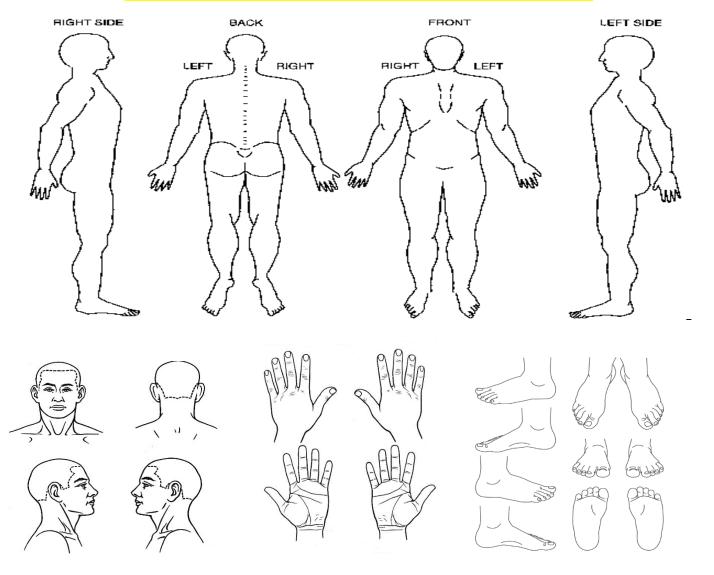
On a scale of O(none) to 10(severe) rate your symptoms.

O(none) 1 2 3 4 5 6 7 8 9 10(severe)

Are your symptoms (circle your answer)-

CONSTANT - 76% - 100% of the time you are awake - all day
FREQUENT - 61% - 75% of the time you are awake - ¾ of the day
INTERMITTENT - 26% - 50% of the time you are awake - half of the day
OCCASIONAL - 1% - 25% of the time you are awake - ¼ of the day or less

MARK ON THESE FIGURES WHERE YOUR SYMPTOMS ARE



SIGNATURE:

DATE: