"Achieving maximum output"
Chiropractic Sports Institute
A Professional Corporation

www. GotCSI.com

Dr. Terry Weyman, D.C., C.C.S.P.
Dr. Aaron Schneider, D.C.

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate:_____ Gender: M__ F___ Social Security #: _____ Driver Lic.#: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

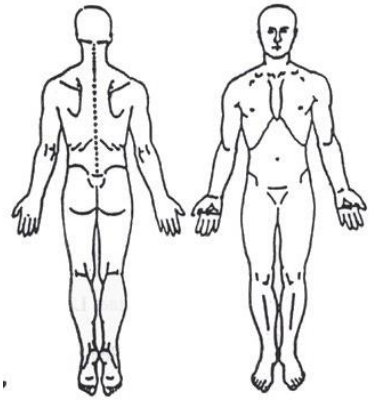
Occupation: _____ Employer: _____Work Phone: _____

Preferred Method of Contact: Home Ph ___ Cell___Work Ph ___

Who may we thank for your referral? _____

Have you consulted a Chiropractor before? Yes ___ No ___ When? _____ Whom? _____

MARK "x" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:



Headache ____ Neck Pain____ Mid-back Pain____ Low Back Pain ____

Other _____

Is this? Work Related: Yes ___ No ___ Auto Related: Yes ___ No ___ N/A ___

Date Problem Began: _____

How Problem Began: _____

Current Complaint(how you feel today):0 __ 1__ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __

No Pain ___ Unbearable Pain___

How often are your symptoms present? O-25% ___ 26- 50% ___ 51-75% ___ 76-100% ___

Can you perform your daily activities? Yes ___ No ____ Describe Current activity limitations: _____

_____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? Yes ___ No ___

Date(s) Taken _____

WHAT AREAS WERE TAKEN? _____

Please check the following that apply to you:

No	Yes	Condition	No	Yes	Condition	No	Yes	Condition
__	__	History of Recent Infection	__	__	Prostate Problems	__	__	Urinary Retention
__	__	Recent Fever	__	__	Frequent Urination	__	__	Aortic Aneurysm
__	__	HIV/AIDS	__	__	Pregnancy, #of births _____	__	__	Cancer/Tumor
__	__	Diabetes	__	__	Abnormal Wt. __ Gain __ Loss	__	__	Osteoporosis
__	__	Corticosteroid Use	__	__	Epilepsy/Seizures	__	__	Recent Trauma
__	__	Birth Control Pills	__	__	Numbness in Groin/Buttocks	__	__	Visual Disturbances
__	__	High Blood Pressure	__	__	History of Low/Mid Back Pain	__	__	History of Alcohol Use
__	__	Stroke (date) _____	__	__	History of Neck Pain	__	__	History of Tobacco Use
__	__	Dizziness/Fainting	__	__	Arthritis			

Surgeries/Medications:_____

Family History: Cancer ___ Diabetes ___ High Blood Pressure ___ Cardiovascular Problems/Stroke ___

I certify that the above information is complete and accurate. I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature _____ Date: _____