Big Beautiful Life

File # _______

Last Name ___________________________ First Name _________________________ BirthDate ________________ Age ______
Address ____________________________________City____________________________State_______ ZIP______________________
Home Phone (____) _______-_____________ Work Phone (____) ______-_________ Cell Phone (____) ______-_____________
Which number is it best to reach you at from 9a-5p? Home Work Cell E-mail address: _______________________________
REFERRED BY: ______________________________ Occupation ____________________ Employer_______________________

Previous Chiropractic Care? Yes / No When and where? ____
Chief complaint (reason you are here): ____
Previous treatments for this complaint: ____
Current medications/drugs being taken: ____
Are you currently under the care of a physician or other health care professionals? ____
Nutritional supplements you are taking: ____
Do you smoke, drink coffee or alcohol? (if yes indicate how much) Cigarettes _________ Coffee__________ Alcohol___________
Do you drink water? Yes / No How much?_____/day How much sugar do you consume per day (sweets, soda, etc)? _________

HISTORY:
List any major illnesses (with approx. dates):____
List any surgery or operations (with approx. date): ____
Past Car Accidents 1____________________________ 2_____________________________ 3___________________________
Past Falls/ Injuries: 1____________________________ 2_____________________________ 3___________________________
Other Traumas: 1______________________________ 2_____________________________ 3___________________________
Other Symptoms/ Conditions:

__headaches	__ neck pain	__asthma	__allergies	__fainting
__migraines	__pins &needles	__chest pains	__loss of smell	__vertigo
__insomnia	__numbness	__breath shortness	__anxiety	__heartburn
__irritability	__tension	__nervousness	__cold extremities	__restricted motion
__depression	__fatigue	__back pain	__diarrhea	**Women:**
__dizziness	__light sensitive	__ear infections	__constipation	__PMS
__ringing in ears	__memory loss	__cold sweats	__stomach upsets	__fibroids
__stiff neck	__frequent colds			__abnormal periods

Have you ever had (please circle): Lyme Disease Mononucleosis

Marital Status: S M D W Name of Spouse_____________________ Describe health of spouse:________________________

Names of Child(ren) if any	Age	Sex	Any physical conditions or concerns?
______________________________	_____	M/ F	____
______________________________	_____	M/ F	____
______________________________	_____	M/ F	____
______________________________	_____	M/ F	____
______________________________	_____	M/ F	____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other ___________________________
Any pets or other animals you or family members are in close contact with?____
What can we do to make you happier?____

SIGNED: ____ **DATE**______________________________________

Copyright © 2005. Dr. Freddie Ulan. All Rights Reserved. Printed in USA.