



The Chiropractic Center of Farmington
Dr. Peter Meadow

Name _____

Date _____

Address _____

Birthdate _____

Sex: ()M ()F Ht. _____ Wt. _____

Phone (Home) _____ (Cell) _____ (Work) _____

Email _____

Musculoskeletal Complaints: E.g., Low back pain, headaches, neck, shoulder, or leg pain, etc. Include in your description whether your problem is acute or chronic; mild, moderate or severe; constant or intermittent; how and when it began; whether it is better or worse with activity; what makes it feel better or worse; what treatments you have tried, etc.

Other Current Complaints: _____

Medical History: List all significant diseases, surgeries, accidents _____

Previous Chiropractic Care: _____

Recent Spinal X-Rays: Date _____ Results: _____

_____/_____/_____
signed date