NEW CLIENT INFO - Short Form ***Dane Roubos, D.C. (541) 821-3263***

Name _____ Birth Date _____ Age ____ Date _____

Name you prefer _____ Hm Phone _____ Cell Phone _____

Street _____ City _____ State ____ Zip _____

Email Address: _____ Ages of Children _____

Occupation _____ Employer _____ Work hrs/week ____

Spouse or Partner's Name _____ Their Occupation _____

Emergency Contact _____ Relationship to you _____

Hm Phone _____ Wk or Cell Ph: _____ City _____ State _____

How did you hear about me? _____ Circle any modalities you've had experience with:
Chiropractic Massage CranioSacral Energy Work Herbs Acupuncture/Pressure Muscle Testing

Briefly list your main health concerns, in order of importance to you (1 = most important).

1. _____ 2. _____ 3. _____

Accidents or Injuries you've had in the past (hard falls, auto/bike accidents, etc.) showing approx Mo/Yr.

Surgeries or Hospitalizations:

Please list any medications or non-prescription drugs that you use currently & how often:

Do you feel stress in your life at home? *None Mild Moderate Severe* ***If yes, please describe:***

At work? *None Mild Moderate Severe* ***If yes, please describe:***

Extended Family? *None Mild Moderate Severe* ***If yes, please describe:***

Please circle your water sources for drinking and cooking: *city tap filtered (brand: _____*
distilled well reverse osmosis glass bottled plastic bottled Other: _____
Please estimate the average amount of plain water you drink each day: ____ glasses, (or) ____ ounces

Family History: *If any of your immediate family has had problems with any of the following, please use this key to indicate which family member after the condition:* I=myself, GF/GM=grandfather/mother, F=father, M=mother, B=brother, S=sister, C=child. Use "2B" to indicate two brothers with the same condition, etc.

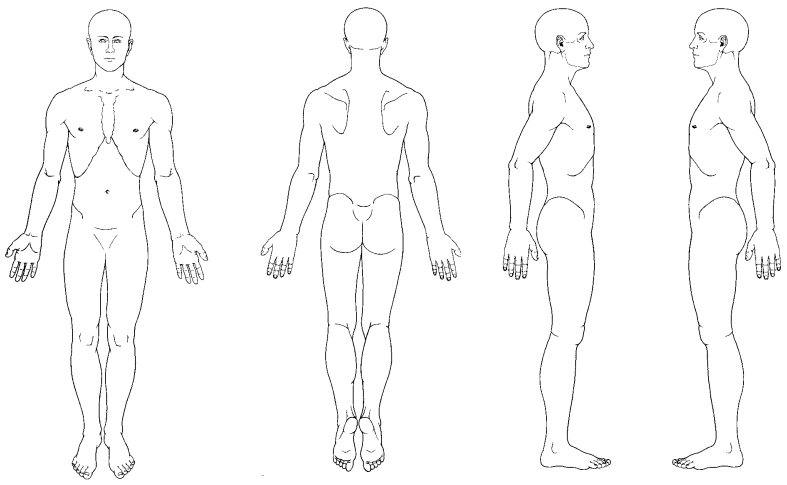
Addiction	Cancer	Headaches - regular	Parasites
Allergies	Constipation	Headaches-migraine	Reproductive
Alzheimer's	Depression	Heart Disease	Sinus
Anger	Dementia	Hi Blood Pressure	Stress - tension
Anxiety	Diabetes	Insomnia	Stomach
Arthritis	Digestion	Intestinal	Thyroid
Asthma	Emphysema	Kidney	Ulcers
AutoImmune	Epilepsy	Liver Problems	Weight
Bowel-colon	Fatigue	Menstrual Pain	*Other*

Circle your Blood Type, if known: A B AB O
Please list any known allergies or sensitivities & what you do to manage or prevent the symptoms:

New client Info (short) - Pg 2 of 2 Date _____ Name _____

Primary Concern covered on this page: _____ *(Please use one page for each concern)*

Instructions: Please shade in your areas of discomfort (or other symptoms).



Onset

When did you first notice this?

It came on: *Suddenly Gradually*

What were you doing at the time, or what do you think caused it? If an injury, describe specifically how it happened, where the impact was, etc:

Radiation: Does the sensation seem to spread out, or "travel" to another area? *Yes No*
(If Yes, indicate this on the drawing above with an arrow, showing where it starts, and where it spreads to)

To what extent might *stress* be contributing to this issue? *(use an "X") None* | - - - - - - - - - - | *A lot*
Since onset, the problem has gotten: *Better Worse Stayed the same Gone up & down Other:*

Symptom Characteristics

Describe what it feels like: *Sharp Dull Achy Throbbing Burning Numb Tingling Other:*
How would you rate the intensity on this scale? *Draw an oval to include the range from best to worst, and place an "X" where it is most of the time: No Problem* | - - - - - - - - - - | *Severe*
How often do you feel this? *(Use an "X") Never* | - - - - - - - - - - | *Constant*

List any time of day, season, or other cycle when it's *better:*

List any timing when it's *worse:*

Does it feel better when you lie down & rest? *Yes No Comments:*

List anything else that makes it *better:*

List anything that makes it *worse:*

Does it affect your sleep? *Yes No* If so, how?

Does this problem limit any of your regular activities? *Yes No* Please describe:

Other Practitioners you have seen for this problem:

1. _____ Their Opinion & Rcmmd: _____
2. _____ Their Opinion & Rcmmd: _____

Have you had similar symptoms in the past? *Yes No* If yes, please give approximate timing and describe circumstance or relation to major events (e.g. mo/year it occurred, shortly after my divorce, etc):

Have you had any *injuries* to this area in the past? *Yes No* If yes, please describe circumstance and give approximate date:

Anything else I should know?

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