Terrance Waggoner, DC
Kelly Garber, DC

Nathan Holley, DC
Megan Holley, DC LAc

Name: _____ DOB: _____

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

Phone #: _____ Employer: _____

Email: _____ Spouse/Parent: _____

Ref By: _____ No. of Children: _____

Insurance: _____

Past Medical History:

Surgeries: _____

Fractured Bones: _____

Major accident/injury: _____

Prescription Medication: _____

Primary Care Physician: _____

What is the reason for your visit? _____
When did this start? _____ How did this happen? _____
How would you describe your pain?

Achy	Sharp	Burning	Numb	Tingling
Throbbing	Cramping	Stabbing	Other: _____	

Have you had this in the past? _____ When? _____

What activities make it worse? _____ What activities make it better?_____

Rate your pain below: 0= No pain, 10= Worst Pain
0 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____ Date: _____