PATIENT INFORMATION

File # _____ Date _____

Patient Information

Thank you for choosing our practice for your Chiropractic needs. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. If you have any questions or concerns, please ask for assistance. We will be happy to help you. Thank You.

Name _____ Date of Birth _____ S/S _____ - _____ - _____

Home Phone _____ Cell Phone _____ Sex: □ Female □ Male

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Primary Language _____

Are you: □ Minor □ Single □ Married □ Domestic Partnership □ Divorced □ Separated □ Widow

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American □ Hispanic

□ Native Hawaiian or Other Pacific Islander □ White

Your Occupation _____ Your Employer _____

Business Address _____ Work Phone _____

Spouse or Parent Name _____ Workplace _____ Work Phone _____

Name of person responsible for this account? _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____ Relationship _____

Whom may we thank for referring you to us? _____

Insurance Information - Please provide us with your insurance card so we can make a copy.

Is this visit related to an accident?

Automobile □ Yes □ No Work Related □ Yes □ No Other □ Yes □ No

Date of injury _____ Time _____ Place _____

Please bring us a copy of your accident report.

Health History

Health Conditions: (i.e. high blood pressure, high cholesterol, diabetes, thyroid) Please list type and year:_____

_____

Accidents / Injuries: Please list type and year _____

_____

_____

Hospitalization / Surgeries: Please list type and year_____

_____

Do you have a pacemaker?	Yes	No	_____
Have you ever had cancer?	Yes	No	_____
Are you losing weight now without trying?	Yes	No	_____
Are you coughing up blood or noticing it in your stools or urine?	Yes	No	_____
Have you had any loss of bladder or bowel control?	Yes	No	_____
Have you lost consciousness or had double vision recently?	Yes	No	_____
Have you had any recent episodes of weakness?	Yes	No	_____
Have you had any recent dental work?	Yes	No	_____
Do you have any other symptoms or health problems?	Yes	No	_____

Have you had a pneumonia vaccination? Yes No Month _____ Year_____

Have you been screened for Colorectal cancer? Yes No _____

FEMALES ONLY

Is there any chance that you are pregnant now? Yes No _____

Date of last menstrual cycle _____ How many children? ___ Vaginal birth ___ C-section ___

Pregnancy complications? Yes No _____

Have you had a mammogram? Yes No Month _____ Year_____

Have you had a pap smear in the last two years: Yes No _____

Are you currently taking any medications? □ Yes □ No If yes, please continue.

Medications / prescribed and over the counter: Please allow us to make a copy of the list you carry with you.

_____ Dosage _____ Frequency _____

_____ Dosage _____ Frequency _____

_____ Dosage _____ Frequency _____

What vitamins or other nutritional supplements do you currently take?

_____ Dosage _____ Frequency _____

_____ Dosage _____ Frequency _____

_____ Dosage _____ Frequency _____

Do you have any medication allergies? □ Yes □ No _____

Family Health History

List immediate family members that have these issues: M = mother P = father B = brother S = sister

MGM = maternal grandmother / MGF = maternal grandfather

PGM = paternal grandmother / PGF = paternal grandfather

Cancer Yes/No What kind?_____

_____

High blood pressure _____ Diabetes Yes/No Type 1 (Insulin Dependent) Type 2

Heart Disease Yes No What kind? _____ Stroke _____

Fibromyalgia _____ Rheumatoid Arthritis _____

High cholesterol _____ Thyroid Yes/No What problems?_____

Osteoporosis _____ Mental Illness _____

Other _____

Wellness

Name of local primary physician _____ Specialists _____

Tobacco use: • Never Smoked • Live with a smoker

• Current every day tobacco use, _____ packs per day. • Current occasional tobacco use, _____ per week. What Type • Cigarettes • Chewing Tobacco • Cigars

• Former tobacco user / Quit Date _____ How long did you use? _____ years

Alcohol consumption: • None • Rarely • Social Drinker • Recovering Alcoholic

• Beer _____ a day • Mixed Drinks _____ a day • Wine _____ a day