Patient Information

File #:_____

Name _____ Sex { M F } Birth Date _____/_____/_____ Age: _____
First Middle Initial Last

Address _____ Cell #._____ Work # _____

City _____ State_____ Zip _____ E-mail:_____

Insurance Company _____ Social Security number _____

Employer _____ Occupation _____

Marital Status:{ M S D W } Spouse/Parent::_____ Driver's License #: _____

Have you had chiropractic care before? _____ When/Where? _____

Who told you about our office? _____

List all surgeries:

_____
_____
_____
_____

List vitamins and non-prescription drugs

_____
_____
_____
_____

Check here if you have a family History of:

☐ Arthritis
☐ Heart disease
☐ Diabetes
☐ Cancer

List all current prescriptions:

_____
_____
_____
_____
_____

Who is your family doctor? Dr. _____
City: _____
May we send a report to your family doctor? ☐ Yes ☐ No

Social Habits: ☐ Tobacco ☐ Alcohol ☐ Coffee
Exercise Activity: ☐ No exercise program ☐ Light exercise ☐ Moderate exercise ☐ Strenuous exercise
Stress level: ☐ None ☐ Minimal ☐ Moderate ☐ Highly stressed (☐ Work ☐ Home ☐ Family ☐ Other)
Physical activity levels: ☐ Sitting 50% or more ☐ Light labor ☐ Manual labor ☐ Heavy labor ☐ Repetitive

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE or HAD

☐ High blood pressure	☐ Nigh sweats	☐ Headahces	☐ New Headache
☐ Asthma	☐ Lung disease	☐ Pneumonia	☐ Sinus Problem
☐ Gastric ulcers	☐ GERD/Acid Reflux	☐ Gas/Bloating	☐ Cancer
☐ Joint pains	☐ Shoulder pain	☐ Hepatitis A B C	☐ Arthritis
☐ Heart Disease	☐ Diabetes	☐ Sinus/Allergies	☐ Seizures
☐ Recent Infection	☐ Emphysema	☐ Kidney problems	☐ Blackouts
☐ Colon Disease	☐ Hiatal hernia	☐ Menstrual pains	☐ Migraines
☐ Jaw pain	☐ Numbness	☐ HIV+	☐ Abuse

May we send a report to your family doctor? ☐ Yes ☐ No

Anything Else to Report? _____
_____
_____

Patient/Guardian Signature:_____ Date: _____/_____/_____

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