PATIENT INFORMATION

Last Name_____ First Name_____ MI____

Address_____

City_____ State_____ Zip_____

Primary Care Provider_____ Referring Provider_____

DOB ____/____/_____ Sex_____ SSN_____-____-_____ Weight_____ Height_____

Marital Status (circle one): **Single** **Married** **Other**

Employment Status_____ Professional Title_____

Smoking ☐**Yes** ☐**No** Frequency_____

Smoking Start Date_____ Smoking End Date_____

Race_____ Ethnicity_____ Religion_____

Preferred Phone: ☐Home ☐Work ☐Cell (_____)_____-_____

Email_____

EMERGENCY CONTACT

Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Home (_____)_____-_____ Work (_____)_____-_____ Cell (_____)_____-_____

MEDICAL HISTORY

Allergies_____

Current Medications_____

Past Chiropractic Care: ☐**Yes** ☐**No** If yes, who/where?_____

_____

Last Physical Examination ____/____/_____

Have you been treated for any health condition by a physician in the last year? ☐**Yes** ☐**No** If yes, explain_____

_____

Have you ever had:

Surgery: ☐**Yes** ☐**No** Fractures: ☐**Yes** ☐**No** Car Accident: ☐**Yes** ☐**No**

Falls: ☐**Yes** ☐**No** On-job Injury: ☐**Yes** ☐**No** Explain:_____

_____

Do you have a family history of:

Heart Disease: ☐**Yes** ☐**No** Cancer: ☐**Yes** ☐**No** Diabetes: ☐**Yes** ☐**No**

Arthritis: ☐**Yes** ☐**No** Back Problems: ☐**Yes** ☐**No** Other: ☐**Yes** ☐**No**

Do you have an Advance Directive on file with your PCP? ☐**Yes** ☐**No**

If you are female, are you possibly pregnant? ☐**Yes** ☐**No**

Date of last menstrual period ____/____/_____

Previous serious illness/hospitalization (please date and describe): _____

_____