NEW PATIENT INFORMATION

Patient: _____ Date:_____

Your Personal Information

Name:_____ Spouse:_____

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

Home Phone:_____ Cell Phone:_____ DOB:_____

Age:____ Email address:_____ Marital Status: ☐ M ☐ S ☐ W ☐ D

Employer:_____ Work Phone:_____

Type of Work/Position:_____

In Case Of Emergency Notify:_____ Phone #:_____

Family Physician:_____ Clinic Location:_____

Can we email you appointment reminders and monthly newsletters? Yes No

Your Current Health Concern

Who Should We Thank For Telling You About Our Office**?**_____

Primary Reason For Today's Visit:_____

What Caused the Complaint:_____

When Did This Begin?_____ Experienced Previously? ☐ Yes ☐ Never

Is This Condition: ☐ Work Related ☐ Auto Accident ☐ Other:_____

Other Health Practitioners Seen For This Problem:_____

Other Practitioners Opinions or Diagnosis:_____

Other Health Concerns: _____

Your Health History

Drugs Or Medications Now Taking: ☐ Pain Killers / Muscle Relaxants ☐ Over Counter
☐ Blood Pressure/Cholesterol ☐ Antibiotics
☐ Other:_____

Describe Any Surgeries: _____

Describe Previous Illnesses/ Diseases: _____

Previous Fractures Or Broken Bones: _____

Previous Hospitalization: _____

Previous Chiropractic Care: _____

Similar Problem In Family: _____

Similar Problems With Co-Workers: ☐ Yes ☐ No Describe:_____

Do You Workout/Exercise? ☐ Yes ☐ No Describe:_____

Number of Alcoholic Beverages Per Week: _____ Tobacco: _____