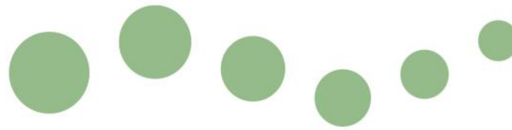
Pt:
Date:



Patient Information

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name________________________________ **Nick Name**________________________________

Last Name ________________________________ **Middle Name** ____________________**Suffix** __________

Date of Birth [/ /] **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** ________________________________

Spouse's Name (if applicable): ______________________**Do you have children? YES NO / How Many?** _____

Address ____

City_________________________________ **State**______________ **Zip Code** _________________________

Mobile Phone______________________________ **(Used for Text Reminders)** ❑ Opt Out of Text Reminders

Primary Phone ______________________________ **Secondary Phone** ________________________________

Home Email___________________________________ **Work Email** ______________________________

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer: _________________________________**How long?** __________**Occupation:** ____________________

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_________ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

DC __________ LMT __________ AA __________

Pt:
Date:

Verification Question *(choose only one question, then give the answer to that question)*

- ❑ What is the name of your favorite pet? ❑ In what city where you born? ❑ What high school did you attend?
- ❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
- ❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: ______________________________

Referral Information

Who can we thank for telling you about our office? ______________________________

Health History

Please list any known ALLERGIES you have had to any medications. If no allergies are known, check here: ❑

1) ______________________ **3)** ______________________

2) ______________________ **4)** ______________________

Please list any medications you are currently taking, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

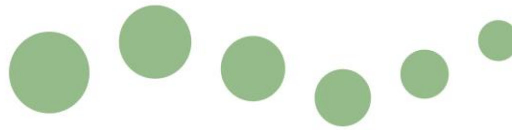
List previous surgeries with dates: ______________________________

____

____

DC __________ LMT __________ AA __________

Pt:
Date:



Reason For Visit

Please describe the pain & its location and any other health conditions: ______________________________

____

____

The reason for this visit is a result of (please circle): **Work** **Sports** **Auto** **Trauma** **Chronic** **Other**

Please explain: ____

____

____

When did condition begin? __________/______/______

Is this condition getting worse (please circle)? **YES** **NO** **Constant** **Comes and Goes**

Is this condition interfering with your (please circle): **Work** **Sleep** **Daily routine**

If so, please explain: ____

____

Have you had this or similar conditions in the past (please circle)? **YES** **NO**

If so, please explain: ____

____

Have you been treated by a Medical Physician for this condition (please circle)? **YES** **NO**

If yes, where? ____

Have you ever been treated by a Chiropractor before (please circle)? **YES** **NO**

If yes, How long ago? ______________ **Do you have a preferred technique?** ____________________

DC __________ LMT __________ AA __________

Pt:
Date:

Health Information

Do you have any of the following diseases or conditions (currently or in the past)?

Y N Heart Attack / Stroke	**Y N Heart Surg. / Pacemaker**	**Y N Heart Murmur**
Y N Congenital Heart Defect	**Y N Mitral Valve Prolapse**	**Y N Artificial Valves**
Y N Alcohol / Drug Abuse	**Y N Venereal Disease**	**Y N Hepatitis**
Y N HIV+ / AIDS	**Y N Shingles**	**Y N Cancer**
Y N Frequent Neck Pain	**Y N Emphysema / Glaucoma**	**Y N Anemia**
Y N High / Low Blood Pressure	**Y N Psychiatric Problems**	**Y N Rheumatic Fever**
Y N Severe / Frequent Headaches	**Y N Kidney Problems**	**Y N Ulcers / Colitis**
Y N Fainting / Seizures / Epilepsy	**Y N Sinus Problems**	**Y N Asthma**
Y N Diabetes / Tuberculosis	**Y N Difficulty Breathing**	**Y N Chemotherapy**
Y N Lower Back Problems	**Y N Artificial Bones / Joints**	**Y N Arthritis**

Please list any other serious medical condition(s) you have or ever had: ____

____

List any past serious accidents with dates: ____

____

Family Health History and relationship: ____

____

Do you take Vitamins or Supplements (please circle)? YES NO Exercise(please circle)? YES NO

Are you on a special diet (please circle)? YES NO Since: __________/___ /_______

<u>For Women:</u> Are you taking Birth control? YES NO If yes, what kind(please circle)? Pill Patch IUD Other

Are you Pregnant (please circle)? YES NO If yes, when is your estimated due date? ________________________

Are you Nursing (please circle)? YES NO

Emergency Contact:

Name: ____ **Relation:** ___________________________________

Phone: ____ **Secondary Phone:** ___________________________________

Current Primary Care Doctor: ___________________________________ **Phone:** ___________________________________

DC ___________ LMT ___________ AA ___________