

Demographic Information

Patient Legal Name: First: _____ Middle Initial: _____ Last: _____

Nickname: (prefer to be addressed as) _____ How did you contact us? _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: _____ Email: _____

Social Security Number: _____ Marital Status: _____ Spouse Name: _____

Employment Status: Employed Full-time student Part-time student Other Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Job Title: _____ Type of Work: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

IF A MINOR Parent/Guardian: Legal Name: First: _____ Middle Initial: _____ Last: _____

DOB: _____ Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Social Security Number: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Completed
This Section
Online

FAMILY HISTORY

Does anyone in your family have a history of (please list relation in the blank beside the condition)?

- Arthritis _____ Diabetes _____ Cholesterol _____
 Cancer _____ Thyroid _____ Psychiatric _____
 Cardiovascular Problems: _____ Stroke _____ Other: _____

Patient's Health and Social History and Review of Systems

Recreational Activities: _____ List Children's Names and Ages _____

Alcohol Frequency of Use: _____ * _____ * _____ *

Substance Use: _____ * _____ * _____ *

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

Current medications, including frequency and dosage if known (Use back of sheet if necessary)

No current medications, check here:

Medication	Frequency	Dosage	Start Date

Have you ever seen a chiropractor? Yes No When? _____ Who? _____

Are you pregnant? Yes No N/A Due Date: _____

List any known allergies you have had to any medications or other. If no allergies are known, check here:

List Any and All Health Problems

Has any doctor diagnosed you with Hypertension? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes? Yes No If yes, what kind? Type I Type II

Please list ALL surgeries and dates: _____

Print Patient Name: _____

Patient/Parent/Guardian Signature: _____ Date: _____

