Chiropractic Care Clinic
NEW PATIENT INFORMATION FORM

Please print clearly:

Name____ Date______________

Address ____ Apt.# _____________

City ____________________________ State____________ ZIP______________

Shipping Address ____

____

Home Phone (____) ____-_________ Work Phone (____) ____-_________

e-mail address: _____________________________________

REFERRED BY:____

Occupation _______________________ Employer___________________________

Date of Birth ________________ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: __________________

Chief complaint (reason you are here): (use separate sheet if more room needed)

____

Previous treatments for this complaint ______________________________________

____

Other complaints or problems: (use separate sheet if needed) ______________________

____

Current medications/drugs being taken: (use separate sheet if needed) _______________

____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

____

Nutritional supplements you are taking: _____________________________________

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes ______________ Coffee ________________ Alcohol_______________

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Chiropractic Care Clinic
NEW PATIENT INFORMATION FORM

Name: ____ Date ______________

HISTORY:

List any major illnesses (with approx. dates): __________________________________

____

List any surgery or operations with approx. date:________________________________

____

Past Accidents or injuries: ____

____

==

Marital Status: S M D W Name of Spouse ____________________________

Describe health of spouse: ______________________ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
________________________	____	M/F	________________________________
________________________	____	M/F	________________________________
________________________	____	M/F	________________________________

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other ____

Any household pets or other animals you or family members are in close contact with:

____

What can we do to make you happier?____

____

SIGNED:____ DATE ____________

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