

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIPCODE \_\_\_\_\_  
 CELL PHONE (\_\_\_\_) \_\_\_\_\_ MARRIED SINGLE WIDOWED DIVORCED  
 DAYTIME PHONE (\_\_\_\_) \_\_\_\_\_ BESIDES YOURSELF, HOW MANY ADULTS LIVE IN YOUR HOME? \_\_\_\_\_  
 NIGHTTIME PHONE (\_\_\_\_) \_\_\_\_\_ HOW MANY CHILDREN LIVE IN YOUR HOME? \_\_\_\_\_  
 EMAIL \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 IN CASE OF EMERGENCY, CONTACT \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
 WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

1. WOMEN

- ARE YOU PREGNANT? YES NO
- HOW MANY FULL TERM PREGNANCIES \_\_\_\_\_

2. ARE YOU CURRENTLY TAKING ANY MEDICATION

MEDICATIONS


3. LIST ALL SURGERY

DATE REASON

DATE	REASON

4. LIST ALL SERIOUS ACCIDENTS, INJURIES OR FRACTURES

DATE REASON

DATE	REASON

5. LIST ANY HOSPITALIZATIONS

DATE REASON

DATE	REASON

6. ARE YOU ALLERGIC TO ANY MEDICATION

MEDICATION


HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? YES NO DR's NAME \_\_\_\_\_

DO YOU HAVE A GENERAL MEDICAL OR OSTEOPATHIC PHYSICIAN YES NO DR's NAME \_\_\_\_\_

DO YOU NOW TAKE VITAMINS OR MINERALS? YES NO DO YOU THINK YOU MAY NEED VITAMINS OR MINERALS YES NO

ARE YOU WEARING FOOT ORTHOTICS? YES NO DO YOU HAVE A LIFT IN ONE SHOE? YES NO

DID YOU PLAY SPORTS IN SCHOOL? YES NO WHAT SPORTS? \_\_\_\_\_

WHAT DO YOU DO FOR PHYSICAL ACTIVITY? \_\_\_\_\_

RIGHT HANDED LEFT HANDED

DO YOU SMOKE? USED TO YES NO HOW MANY ALCOHOLIC BEVERAGES DO YOU HAVE IN A WEEK? \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_