Submit by Email Print Form

Welcome to Our Practice

Name: _____ Home/Cell Phone: _____
Address: _____ City: _____ State: ____ Zip: _____
Date of Birth: _____ Gender: M F Spouse's Name: _____
Occupation: _____ Work Phone: _____
Referred by: _____ Your E-mail _____
I'm interested in: ☐ Relief care only ☐ Improving my overall health and well-being

Personal Health History

What is your current health challenge? _____
_____
When did you first notice this problem? _____
Do you smoke? _____ Do you drink coffee? _____ Do you drink alcohol? _____
Do you take any prescription, over-the-counter or recreational drugs? List names or types: _____
_____

Do you take any nutritional supplements? _____ List names: _____
_____

Do you exercise? Regularly ☐ Infrequently ☐ Seldom ☐ Never ☐
Ladies: Are you, or could you be, pregnant now? ☐ Are you post-menopausal? ☐
Have you had any surgeries (please list)? _____
_____

List any previous significant injuries (slips, falls, auto accidents, etc.) and give dates
_____
_____

Have you seen a Chiropractor before (if yes, when and for what)? _____
_____

List any known allergies: _____
_____

On a 0-10 scale (0=none, 10=the worst), what is your overall level of life stress? _____
What is your expectation of your visit today? _____
_____

All of your information is confidential and will not be shared with anyone without your written consent. Occasionally we might want to send personal information to you by email. Check here ☐ if we have your permission to do. All confidential information is transmitted via VPN (Virtual Private Network).

Signed: _____ Date: _____
(Parent or Guardian Signature if under 18) Guardian's name (and address, if different):

_____

Print Form