

## New Patient Info

Name: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: M F No. of Children: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Marital Status: M S D W Spouse's Name: \_\_\_\_\_  
Referred by: \_\_\_\_\_ E-mail \_\_\_\_\_

## Personal Health History

What is your current health challenge? \_\_\_\_\_  
\_\_\_\_\_

When did you first notice this problem? \_\_\_\_\_  
\_\_\_\_\_

Have you had any childhood diseases (please list) \_\_\_\_\_

Immunizations? (please list) \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Do you drink coffee? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_

Do you take any prescription, over-the-counter or recreational drugs? \_\_\_\_\_ List  
names/types: \_\_\_\_\_  
\_\_\_\_\_

Do you take any nutritional supplements? \_\_\_\_\_ List names: \_\_\_\_\_  
\_\_\_\_\_

Do you exercise? \_\_\_\_\_ Regularly \_\_\_\_\_ Infrequently \_\_\_\_\_ Seldom \_\_\_\_\_

Are you pregnant now? \_\_\_\_\_ Are you post-menopausal? \_\_\_\_\_

Do you have a pacemaker? \_\_\_\_\_ 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your expectation of your visit today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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