Welcome to Cline Chiropractic Rehabilitation Center

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Today's Date:____/_____/_____

Patient Name:_____
Last First M.I.
What You Prefer To Be Called:_____
Mailing Address:_____
_____
City State Zip
Cell Phone #:_____
Home Phone #:_____ ☐ Male ☐ Female
Work Phone #:_____
Email:_____ **Birthdate**:____/____/____ **Age:**_____
SS#:_____
Marital Status (*please circle one):* **Minor Single Married Divorced Separated Widowed**
Spouses Name:_____
Do You Have Any Children:_____ How Many?_____
Referred By:_____
Employer:_____How Long?_____
Occupation:_____
Race (*Please circle one*): **American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Decline to Provide**
Ethnicity (*Please circle one*): **Hispanic or Latino Not Hispanic or Latino Declined to Provide**
Preferred Language:_____
Do you Smoke? _____ (*Please Circle One*): **Currently Everyday Current Some Day Smoker Former Smoker Never Smoker**

In Event of Emergency

Who should we contact:_____
Relation:_____
Home Phone#:_____ Work Phone#:_____
Who is your Medical Doctor?_____ Phone#:_____

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic
(*Explain what happened*):
_____
_____
Please describe the pain and its location:_____
When did condition begin:____/____/____
Is this condition getting worse?_____ ☐ constant ☐ comes and goes
Is this condition interfering with you (*Please circle*): **work sleep daily routine**
If so, please explain:_____
Have you had similar conditions in the past?_____
If so, please explain:_____
Have you been treated by a Medical Physician for this condition?_____
If so, where?_____
Have you ever been treated by a Chiropractor before?_____
If so, whom?_____ Phone#:_____

Are you taking any medications? (*If so, please list*)

_____

_____

Are you allergic to anything? (*Foods, medications, etc.)*

_____

_____

Do you have or ever had any of the following diseases or conditions? (*Please Circle*)

Heart Attack	Heart Surgery/Pacemaker	Heart Murmur
Stroke	Mitral Valve Prolapse	Artificial Valves
Alcohol/Drug Abuse	Venereal Disease	Hepatitis
HIV+/Aids	Shingles	Cancer
Frequent Neck Pain	Emphysema	Anemia
High Blood Pressure	Glaucoma	Rheumatic Fever
Low Blood Pressure	Psychiatric Problems	Ulcers
Severe/Frequent Headaches	Kidney Problems	Colitis
Fainting/Seizures/Epilepsy	Sinus Problems	Asthma
Diabetes/Tuberculosis	Difficult Breathing	Chemotherapy
Lower Back Problems	Artificial Bones/Joints	Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

List previous surgeries/treatments with dates:

_____

List any PAST serious accidents with dates:

_____

Family Health History:

_____

Do you: Take Supplements or Vitamins: _____ Exercise? _____

Are you on a special diet? _____ Since:____/____/____

Are you wearing (*Please circle*): **Heel Lifts** **Sole Lifts** **Inner Soles** **Arch Supports**

What is the age of your mattress?_____ Is it comfortable?_____

For Women: Are you taking birth control? _____

Are you pregnant?_____ How far along?_____ Nursing?_____

- In order to provide quality service, we encourage our patients to disclose any questions that may arise. Shared knowledge between provider and patient fosters mutual understanding.
- I authorize the staff at Cline Chiropractic to perform any required services throughout my diagnosis and treatment.
- I authorize that the given information is correct to the best of my knowledge. I understand the necessity of informing front office staff of any changes to the information provided above.

Signature _____ Date:____/____/____

☐ Adult Patient ☐ Parent/Guardian ☐ Spouse