Comprehensive Chiropractic & Rehab™

**Name**: _____ **Date of birth**: _____/_____/_____ **SSN**: _____

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Home Phone**: _____ **Cell**: _____ **Email**: _____

**Preferred method for appt reminders**: ☐ EMAIL ☐ TEXT, if text messages, who is your service provider? _____

**Gender Identity:** ☐ Male ☐ Female **Work Status:** ☐ Full ☐ Part ☐ Retired **Student Status**: ☐ Full ☐ Part ☐ N/A

**Marital Status**: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partnership ☐ Widowed ☐ Decline

**OPTIONAL QUESTIONS: Preferred Language:** ☐_____ ☐ Decline ☐ Blank

**Race:** ☐ American Indian ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White ☐ Decline ☐ Blank

**Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline ☐ Blank

**Emergency Contact**: _____ **Phone #**: _____ **Relation**: _____

**Current Primary Care Physician/Practice**: _____

## MEDICAL HISTORY

Please indicate whether you have had or currently have any of the following:

| | | | | |
|---|---|---|---|---|
| ☐ Heart Disease | ☐ Chronic Lung Disease | ☐ Diabetes | ☐ Cancer | ☐ Arthritis |
| ☐ High Blood Pressure | ☐ Hepatitis | ☐ Asthma | ☐ Stomach Problems | ☐ Kidney Issues |
| ☐ Muscular-skeletal | ☐ Neurological/Seizures | ☐ Psychological/Psychiatric Disorders | | ☐ Anemia |

**History of previous injuries, surgeries, hospitalizations or motor vehicle accidents**: _____

_____

**Family History of illness**: _____

**CURRENT MEDICATIONS**: _____

**ALLERGIES**: _____

**Have you had any spinal x-rays or MRIs in the past 5 years**? ☐ Yes ☐ No When_____ Where _____
**Previous chiropractic treatment**? ☐ Yes ☐ No If yes, last date of treatment _____ By whom: _____

**Do you do any of the following on a regular, daily basis:**

**Exercise?** ☐ Yes ☐ No _____ hours per week, includes activities: _____
**Drink?** ☐ Yes ☐ No _____ drinks per week **Smoke?** ☐ Yes ☐ No _____ # of years _____ # packs per day

**Do you wear any of the following?** Heal Lifts ☐ Yes ☐ No Arch Supports ☐ Yes ☐ No Prescription Orthotics ☐ Yes ☐ No

**How were you referred**? ☐ Drive By/Walk-in ☐ Internet ☐ Business Referral _____ ☐ Referred by _____

**What types of services are you interested in?** ☐ Chiropractic Consultation ☐ Adjustment ☐ Acupuncture ☐ Massage Therapy
☐ Personal Training ☐ Nutritional Counseling ☐ Durable Medical Equipment ☐ Custom Orthotics ☐ Cupping Therapy
☐ Alternative/Holistic Options ☐ NutraMetrix Products ☐ Other_____

**Reason for today's visit**: _____

Patient Signature: _____ Date: _____/_____/_____

Doctor Signature: _____ Date: _____/_____/_____

**OFFICE USE:**

**Payer Type**: ☐ Self-Pay ☐ Private Health Insurance ☐ Medicare ☐ Auto ☐ Workers Comp ☐ Personal Injury ☐ LOP