



Dr. Jacquelyn Gates, D.C.

*GatesChiropractic

AKA: Mobile Chiropractic Health w/ Equine, Canine

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816-525-1525

Patient Information

Patient Full Name _____

Home Phone Number _____

Date of Birth _____

Cell Phone Number _____

Current Age _____

Employer _____

Street Address _____

Occupation _____

City _____

How were you referred? _____

State _____

Name of emergency contact/phone number _____

Zip Code _____

Have you previously had any chiropractic care? _____ Date of last visit _____

Have you previously had any massage therapy? _____ Date of last massage _____

Primary care physician _____

Primary care physician contact information _____

List any major surgeries with dates of treatment _____

List any major trauma/injuries (ex- whiplash injuries, lifting injuries, falls, etc) with dates of incident _____

How would you rate your current health? Great/good/fair/needs improvement/poor (circle one)

What portion of your day is spent sitting? 0-25% 25-50% 50-75% 75-100% (circle one)