Miracles Health Care Center

TOTAL BODY RELEASE CHIROPRACTIC CARE

Patient Registration Information

Date _____/_____/_____

Name: Last:_____ First:_____ M.I._____

Address: _____

City: _____ State: _____ Zipcode: _____

E-mail Address: _____

Telephone: (_____)_____ Cell Phone: (_____)_____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ Cell Phone: (_____)_____

Patient's Occupation: _____

Patient's Employer: _____

Emergency Contact: Name:

Phone: Relationship:

Please list any surgeries or hospitalizations: *(use back of page if more space is needed)*

Date:

Date:

Please list any Injuries, Broken Bones, Auto Accidents, ect: *(use back of page if more space is needed)*

Date:

Date:

Please list any medications you are currently taking: *(use back of page if more space is needed)*

1.	3.	5.
2.	4.	6.

Do you or your family have a history of any of the following? *(ck box, then list… self, brother, uncle, ect. on line)*

	Heart Disease	Arthritis	Cancer	Diabetes	Other…	Specify What:
Self / Siblings	☐_____	☐_____	☐_____	☐_____	☐_____	_____
Father's Side	☐_____	☐_____	☐_____	☐_____	☐_____	_____
Mother's Side	☐_____	☐_____	☐_____	☐_____	☐_____	_____

Patient Signature: _____ Date: _____

804 Central St. W., Bagley, MN
224 2nd Ave. S.E., Clearbrook, MN
www.doc-mari.com

Contact: Dr. Mari Schwartz D.C.
Phone: (320) 339-0477
Email: docschwartzdc@gmail.com