Family Care Chiropractic

Jaime Gonzalez, D.C.
Justin Ross, D.C.
10110 Dixie Highway, Louisville, KY 40272

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

First Name_____ Nick Name_____

Last Name _____ Middle Name _____Suffix _____

Address 1 _____

Address 2 _____

City_____ State_____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

By providing my mobile number / email address, I authorize my doctor to contact me text or email address.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth: _____ Age _____ Gender *(check one)* ❑ Male ❑ Female

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other Social Security Number: _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Please list your current medications if any:

Please list your current medications, including frequency and dosage if known and when you starting taking them.
If there are no current medications, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

0 = No Pain, 10 = Extreme Pain

Briefly list your main health problems or areas of pain and rate each from 0 to 10: _____

_____

_____

Have you had an X-ray or CT scan or MRI of your neck, mid back or low back in the past 30 days? ❑ Yes ❑ No

If so, where? _____ What was the diagnosis? _____

_____
Dr. Intials

Health History:

What treatment have you already received for this condition:

Chiropractic Care Medication Surgery Physical Therapy Other: _____

Please mark YES or NO if you have or have had any of the following:

AIDS / HIV	O Yes	O No	Diabetes	O Yes	O No	Liver Disease	O Yes	O No	Rheumatic Fever	O Yes	O No
Alcoholism	O Yes	O No	Emphysema	O Yes	O No	Measles	O Yes	O No	Scarlet Fever	O Yes	O No
Allergy Shots	O Yes	O No	Epilepsy	O Yes	O No	Migraine Headache	O Yes	O No	Stroke	O Yes	O No
Anemia	O Yes	O No	Fractures	O Yes	O No	Mononucleosis	O Yes	O No	Thyroid Problems	O Yes	O No
Appendicitis	O Yes	O No	Glaucoma	O Yes	O No	Multiple Sclerosis	O Yes	O No	Tuberculosis	O Yes	O No
Arthritis	O Yes	O No	Gout	O Yes	O No	Mumps	O Yes	O No	Tumors / Growths	O Yes	O No
Asthma	O Yes	O No	Heart Disease	O Yes	O No	Osteoporosis	O Yes	O No	Ulcers	O Yes	O No
Bronchitis	O Yes	O No	Hepatitis	O Yes	O No	Pacemaker	O Yes	O No	Whooping Cough	O Yes	O No
Cancer	O Yes	O No	Herniated Disc	O Yes	O No	Parkinson's	O Yes	O No	Other: _____		
Cataracts	O Yes	O No	High Blood Pressure	O Yes	O No	Prosthesis	O Yes	O No	_____		
Chicken Pox	O Yes	O No	High Cholesterol	O Yes	O No	Psychiatric Care	O Yes	O No	_____		

For any YES marked above, please explain: _____

_____

Please describe any other pertinent information: _____

_____

Family History:

Do any of your parents or their parents have or had stoke, high blood pressure, high cholesterol, diabetes heart attack or cancer?

Mother: Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Father: Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Mother's mother:
Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Father's mother:
Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Mother's father:
Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Father's father:
Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

" I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct: I am not attempting to investigate <u>Family Care Chiropractic</u> as a representative of any agent or entity, or any insurance company or other organizational entity or person".

Please Print Patient Name Patient or Guardian Signature Date:

_____ _____ _____

_____
Dr. Intials