

LE CHIROPRACTIC
NEW PATIENT INFORMATION FORM

Page 1 of 2

Please print clearly:

Name _____ Date _____

Address _____ Apt. # _____

City _____ Zip _____

Shipping Address _____

Home Phone (____) ____-____ Work Phone (____) ____-____

E-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatment for this complaint _____

Other complaint of problems: (use separate sheet if needed) _____

Current medications/drugs being taken :(use separate sheet if needed) _____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

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Office Use Only:

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Page 2 of 2

Name _____ Date _____

HISTORY:

List any major illnesses (with approx. dates): _____

List any surgery or operation with approx. date: _____

Past Accidents or injuries: _____

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Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions of concerns?
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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Any family history of serious illness (circle those which apply): Cancer / Diabetes / Heart
Others _____

Any household pets or other animals you or your family members are in close contact
with: _____

What can we do to make you happier? _____

SIGNED: _____ DATE _____