DATE: _______________ Cell Phone Provider: _____________________

PATIENT: ____Phone#: _______________________

ADDRESS: ____________________________________CITY:_________________STATE:_____ZIP:________

BIRTHDATE: ______________ SEX: M____F____ MARITAL STATUS: S M W D

EMAIL: ___________________________________TYPE OF INSURANCE: ______________________________

EMPLOYER: ____ CITY: ____________________________

SPOUSE OR PARENT NAME: ___________________________ SPOUSE DOB: _____________________

MEDICAL AND LEGAL INFO:

PREGNANT: YES: _____ NO: _____ PACEMAKER: YES: ____ NO: _____

FAMILY PHYSICIAN: __________________________PHYSICIAN REFERRED BY: _____________________

IS THIS A WORK OR AUTOMOBILE ACCIDENT? YES: ____ NO: ____

HAVE YOU HAD ANY SPINAL INJECTIONS: YES:______ NO:______ IF YES HOW MANY?___________

EMERGENCY CONTACT: ____
NAME RELATIONSHIP PHONE

REFERRED BY: ____

MAJOR COMPLAINT FOR YOUR VISIT TODAY____

LANGUAGE:
___ENGLISH
___SPANISH
___OTHER

ETHNICITY:
__DO NOT WISH TO PROVIDE THIS INFO
__ HISPANIC OR LATINO
__ CAUCASIAN
__ OTHER__________________________

HEIGHT: _____FEET ______ INC
WEIGHT: _________ LBS
SMOKING STATUS: _____ NO
______ YES _____ FORMER

RACE:
__DO NOT WISH TO PROVIDE THIS INFO
__WHITE
__BLACK OR AFRICAN AMERICAN
__AMERICAN INDIAN OR ALASKA NATIVE
__ASIAN
__NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
__OTHER______________________________

MEDICAL CONDITIONS:
____ DIGESTIVE ISSUES
____ HEART ISSUES (CHOLESTEROL)
____WEIGHT
____ STRESS/DEPRESSION/ANXIETY
____ HORMONES (FEMALE/MALE)
____ INFLAMMATION (ARTHRITIS)
____ SUGAR ISSUES (DIABETES)
____ SLEEPING ISSUES
____ THYROID ISSUES
____ INFECTIONS (ALL TYPES)
____ NONE OF THE ABOVE

MEDICATION ALLERGIES:
___ NO KNOWN MED. ALLERGIES
___ YES WHAT? __________________

CURRENT MEDICATIONS:
___ NO MEDICATION AT THIS TIME ___ YES WHAT? ___________________________________