

Excel Family Chiropractic & Wellness
NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ 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: _____

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

Previous treatments for this complaint _____

Other complaints or 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 _____

=====

Office Use Only:

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Name: _____ Date _____

HISTORY:

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

List any surgery or operations with approx. date: _____

Past accidents or injuries: _____

Describe health of spouse (if applicable): _____

Number of children, if any _____

| Name of child(ren) | Age | Sex | Any physical conditions or concerns? |
|--------------------|-----|-----|--------------------------------------|
|--------------------|-----|-----|--------------------------------------|

| | | | |
|-------|-------|-----|-------|
| _____ | _____ | M/F | _____ |
|-------|-------|-----|-------|

| | | | |
|-------|-------|-----|-------|
| _____ | _____ | M/F | _____ |
|-------|-------|-----|-------|

| | | | |
|-------|-------|-----|-------|
| _____ | _____ | M/F | _____ |
|-------|-------|-----|-------|

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

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

What are your goals regarding your health? _____

SIGNED: _____ DATE _____