Andrews Chiropractic

Confidential Patient Information

Date:__________________

Patient Information

Name (First/M.I./Last):____ Social Security #:________________

Address:____

City:____ State:________ Zip Code:_______________

Birth Date:__________________ Age:_________ Marital Status: ☐M ☐S ☐W ☐D ☐Child

Occupation:__________________________________ Employer:_______________________________________

Spouse/Parent Name:____

How were you referred to our office?____

Have you ever received chiropractic care? ☐Yes ☐No If yes by whom?________________________________

Contact Information

Home Phone:__________________________ Email:____

Cell Phone:____________________________ Cell Carrier (required for text reminders):___________________

Contact Preference: ☐Home Phone Call ☐Cell Phone Call ☐Text Message ☐Email

Emergency Contact:______________________________________ Phone Number:________________________

Patient Health History

Do you currently have or have you ever suffered recurrently from any of the following:

	Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Dizziness	☐	☐	Neck Pain/Stiffness	☐	☐
Sleeping Problems	☐	☐	Back Pain/Backaches	☐	☐	Shoulder Pain	☐	☐
Chest Pain	☐	☐	Fatigue	☐	☐	Nervousness	☐	☐
Ears Ringing/Buzzing	☐	☐	Loss of Balance	☐	☐	Fainting	☐	☐
Cold Feet/Hands	☐	☐	Numbness in Fingers/Toes	☐	☐	Pins/Needles in Arms/Legs	☐	☐
Stroke	☐	☐	Asthma	☐	☐	Sinus Troubles	☐	☐
Digestive Disorders	☐	☐	Diarrhea	☐	☐	Constipation	☐	☐
Heart Trouble	☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐
Anemia	☐	☐	Depression	☐	☐	Diabetes	☐	☐
Tuberculosis	☐	☐	Arthritis	☐	☐	Cancer	☐	☐
AIDS	☐	☐	Systemic Disease	☐	☐	Circulation Disorder	☐	☐

Have you been treated for any health condition by a doctor in the last year? ☐Yes ☐No

If yes please describe: ____

____

Have you had any previous illnesses, diseases or conditions? ☐Yes ☐No

If yes, please describe and list dates: ____

____

Have any of your immediate family members (parents/siblings) had any major health issues? ☐Yes ☐No

If yes, please describe:____

____

Do you have any allergies? ☐Yes ☐No If yes, what are they?______________________________________

	Type	Date		Type	Date
Surgical History:	____________________	___________	Accident History:	___________________	____________
	____________________	___________		___________________	____________
	____________________	___________		___________________	____________
	____________________	___________		___________________	____________

Current medications (<u>include all prescriptions, over the counter medications, vitamins, herbs and minerals</u>)

Medication Name	Dose	Route	Frequency	Length of time
_____________________________________	___________	___________	____________	___________
_____________________________________	___________	___________	____________	___________
_____________________________________	___________	___________	____________	___________
_____________________________________	___________	___________	____________	___________
_____________________________________	___________	___________	____________	___________
_____________________________________	___________	___________	____________	___________

Do you smoke? ☐Never ☐Former Smoker ☐Yes (some days) ☐Yes (everyday) Packs per day______

How much coffee do you drink? ____/day ____/week How much soda do you drink? ____/day ____/week

How much alcohol do you drink? ____/day ____/week

Condition for which you are seeking care:____

Have you ever had this condition before? ☐Yes ☐No When?______________________________________

Names of doctors seen for this condition?____

When did the problem start?____________________________ Is it getting better or worse: ☐Better ☐Worse

In your opinion, what may have caused this condition?____

Anything else you would like me to know:____

____