Bidwell
CHIROPRACTIC

Patient's Name: _____

Date: _____

What is the reason for your visit today?

_____

Is *today's problem caused by:* □ Auto Accident □ Workman's Compensation □ Slip and Fall □ Other

Personal Information

Address _____
City/State/Zip_____

Phone # _____ (home) _____ (cell) _____

E-mail _____ □ Do not wish to receive newsletters

SS# _____ Birth Date _____ Age _____

Height _____ Weight _____ ***Blood Pressure*** _____ □ Male □ Female

Race: □ I - American Indian or Alaskan Native □ A - Asian □ B - Black or African American

□ P - Native Hawaiian or Pacific Islander □ W - White □ E - Other □ 7 - Declined

Ethnicity: □ H - Hispanic or Latino □ N - Not Hispanic or Latino □ 7 - Declined

Preferred Language: _____

Marital status: Single Married Separated Divorced Widowed

Spouse's name (if applicable): _____

Children's names and ages:

_____

Occupation: _____
Employer:_____ Work Phone: _____

Work Address: _____

Is it okay to contact you at work? □ No □ Yes

Emergency contact:

Name_____Relationship_____

Phone #(s) _____

Primary Care Doctor (name, address, phone number):

_____

_____

How did you hear about our office?

_____

Are you pregnant? □ No □ Yes If yes, how far along are you? _____

Smoking Status (circle one):

Never Smoked	Former Smoker	Current Everyday Smoker	Current Some Day Smoker	Light Tobacco Smoker	Heavy Tobacco Smoker

List any new prescription medications you are currently taking:
Check here if you are not currently taking any medications □

Medication *i.e. Lipitor*	**# of MD Refills Issued?**	**Quantity of Pills**	**Strength** *i.e. 10mg*	**Dose Form** *i.e. Capsule*	**MD's Instructions** *i.e. 1 per day*

List any new allergies you may have:
Check here if you do not have any allergies □

Allergen *i.e. penicillin*	**Symptom** *i.e. headache*	**Severity** (circle one)
		Mild Moderate Severe
		Mild Moderate Severe
		Mild Moderate Severe

List any new over the counter medications and supplements you are currently taking:

_____

_____

List any new surgical procedures you have had:

_____

_____

Have you had significant past trauma? (including MVA) □ No □ Yes
If yes, what?

_____

_____

Patient Signature: _____ Date: _____