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) ____

One GOAL you want to achieve with chiropractic care? ____________________________________

How long have you had this problem? ____________________

How do you think your problem began?______________________

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: _______________________