Natural Healing Through Chiropractic Care

Patient Information		DESCRIPTION IT COOL		
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Thank you for choosing our practice for yo	ur chiropractic need	s. Please complete	this form in ink. If yo	u have any questions
concerns, do not hesitate to ask for assista (Please Print)	nce. We will be happ	y to help.	,	
Name /			ALEXY OF STREET	-9h
First MI	Tast Date _	Pati	ent No.	S/S
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Address Sex: ☐ Female ☐ Male	City	Streepte 1	State	Zip
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Birth date	Tionie phone #	7 11/2-1-	☐ Work phone	#
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Your employerBusiness Address		_ Occupation _	ABAIFA I	
Business Address Spouse's or parent's name	117	City	State _	Zip
Spouse's or parent's name		orkplace	Work p	hone #
Whom may we thank for referring you to Person to contact in case of emergency	o us:			
t cross to contact in case of entergency			Phone #	
Responsible Party				•
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Name of person responsible for this acco	ount?	· · · · · · · · · · · · · · · · · · ·		_ S/S
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Reason for visit When did you first notice the symptoms?				
Is this condition getti	ng progressively worse?			
Where specifically is	the problem(s) located?		T Y	
Which activities are d	lifficult to perform? 2 Sitti	ng 2 Standing 2 Walk	ing 2 Bending 2 Lying	down 2 Other
Type of pain: 3 S	harp 2 Dull 2	Throbbing J Numbnes	s D Aching D Shoo	
MC I DE	Burning 3 Tipgling 3			20,000,000
Rate the severity of y	our pain. (1. mild pain or di	scomfort, to 10, severe pa		6 7 8 9 11
Is the pain constant or	r does it come and go?			
What treatment have	you already received for you	ir condition?	Maria North And An	
		cal Therapy 3 Oth	er	
Name and address of	other doctor(s) who have tre	eated you for your conditi	on: - <	

Health Hist	tory		·	
	ditions which are applicable	:		
□ AIDS/HIV	☐ Cataracts		7 Octobronia	7 Cuisida Luama
2 Alcoholism	2 Chemical Dependency	2 Hepatitis 2 Hemia	☐ Osteoporosis ☐ Pacemaker	☐ Suicide Attemp ☐ Thyroid Proble
J Allergy Shots	I Chicken Pox	2 Hemiated Disc	2 Parkinson's Disease	2 Tonsillitis
J Anemia	3 Depression	2 Herpes	J Pinched Nerve	3 Tuberculosis
2 Anorexia	2 Diabetes	2 High Cholesterol	I Pneumonia	2 Tumors. Growt
2 Appendicitis	2 Emphysema	· 2 Kidney Disease	2 Polio	3 Typhoid Fever
2 Anhritis	2 Epilepsy	Liver Disease	3 Prostate Problems	2 Ulcers
J Asthma	2 Fractures	☐ Measles	2 Prosthesis	3 Vaginal Infection
Bleeding Disorders	I Glaucoma	3 Migraine Headaches	2 Psychiatric Care	2 Venereal Disea
3 Breast Lump	2 Goiter	3 Miscarriage	2 Rheumatoid Arthritis	2 Whooping Cou
2 Bronchitis	☐ Gonorrhea	J Mononucleosis	J Rheumatic Fever	J Other
3 Bulimia	J Gout	2 Multiple Sclerosis	J Scarlet Fever	
J Cancer	J Heart Disease	☐ Mumps	⊇ Stroke	
Dates of last exams			, j	
Women) Are you preg	mant? I Yes I No Nur	sing? I Yes I No Ta	king birth control pills?	Yes D No
	ries which you have had and			
cin mily types of saige	ites witten los tiere ima en	s are asses which may bee	, united,	event l
Please list all medication	ons you are currently taking			11.5
Allergies:				
Daily Habit	2		a i	
That has of success	do unu nacione an a daile. L	asis? J None	☐ Moderate ☐ Hear	
	do you perform on a daily b			100 MOCO
what do your daily wo	rk habits include? (ex: sittin	y, standing, light 1800f. A	cavy labor. computer work	
What vitamins do you co	urrentlý take?			
What kind of other nutri	tional supplements do you tal	ke (if any)?		
Do you smoke? I No	J Yes How much per d	ay?		
low much liquor do voi	consume on a weekly basis?	1		
	feinated beverages do you con			
Authorizatio	on .			
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