# Always Gentle Chiropractic

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## ***PATIENT INFORMATION FORM***

TODAYS DATE _____/_____/_____

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ CITY _____ ST_____ ZIP _____

HOME PH_____ CELL_____ EMAIL _____

SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

NUMBER OF CHILDREN ____ NAMES & AGES _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE # _____

IN CASE OF AN EMERGENCY WHOM SHALL WE NOTIFY; _____ PH _____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE ? YES / NO DOCTOR'S NAME? _____

WHEN WAS YOUR LAST VISIT THERE? _____ IS IT POSSIBLE YOU ARE PREGNANT? YES ☐ NO☐

ARE YOU HERE BECAUSE OF AN: ON THE JOB INJURY / AUTO ACCIDENT? DATE OF ACCIDENT_____

***WHAT SYMPTOMS DO YOU HAVE, WHERE DO YOU HURT, HOW BAD AND FOR HOW LONG?***

_____

_____

**HAVE YOU EVER HAD ANY FALLS, BROKEN BONES, ACCIDENTS, OR INJURIES** ***YES ☐ NO☐***

| MONTH/YEAR | TYPE OF ACCIDENT | DESCRIBE INJURY FROM THIS ACCIDENT |
|---|---|---|
| | | |
| | | |
| | | |

**HAVE YOU EVER HAD ANY SURGERIES?** ***YES ☐ NO☐***

| MONTH/YEAR | TYPE OF SURGERY | DESCRIBE REASON FOR SUGERY |
|---|---|---|
| | | |
| | | |
| | | |

| | 1-2 times weekly | 3-5 times weekly | 6-8 times weekly | 9 or more weekly |
|---|---|---|---|---|
| **Do you currently use ALCOHOL, if YES;** | [ ] | [ ] | [ ] | [ ] |
| **Do you currently use COFFEE / TEA if YES;** | [ ] | [ ] | [ ] | [ ] |
| **Do you currently EXERCISE , if YES;** | [ ] | [ ] | [ ] | [ ] |
| **Do you currently use TOBACCO, if YES;** | [ ] | [ ] | [ ] | [ ] |

***PRESENTLY TAKING ANY MEDICATIONS ? YES [ ] NO [ ] VITAMINS / MINERALS ? YES [ ] NO [ ]***

| NAME OF DRUG | DOSES PER DAY | WHAT ARE YOU TAKING THIS MEDICATION FOR? |
|---|---|---|
| | | |
| | | |
| | | |

***PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU ARE HAVING DIFFICULTY WITH***

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chest pains
- ☐ Cold feet
- ☐ Cold hands
- ☐ Cold sweats
- ☐ Concussion
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Face flushed
- ☐ Fainting
- ☐ Fatigue
- ☐ Gallbladder trouble
- ☐ Grating in neck
- ☐ Hayfever
- ☐ Head feels too heavy
- ☐ Headaches
- ☐ Heart attack
- ☐ Heart pain
- ☐ Heart palpitation
- ☐ High blood pressure
- ☐ Indigestion
- ☐ Inner tension
- ☐ Intestinal gas
- ☐ Irritability
- ☐ Kidney trouble
- ☐ Light bothers eyes
- ☐ Liver trouble
- ☐ Loss of balance
- ☐ Loss of memory
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Low back pain
- ☐ Menstrual cramps
- ☐ Menstrual irregularity
- ☐ Mid back pain
- ☐ Muscle spasms in neck
- ☐ Muscle spasms in mid back
- ☐ Muscle spasm in low back
- ☐ Neck pain
- ☐ Nervousness
- ☐ Nervous stomach
- ☐ Numbness in arms and hands
- ☐ Numbness in legs and feet
- ☐ Pain in legs and feet
- ☐ Pain in shoulders and arms
- ☐ Painful joints
- ☐ Rheumatic fever
- ☐ Ringing in the ears
- ☐ Shooting head pain
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Sleeping problems
- ☐ Stomach trouble
- ☐ Swollen ankles
- ☐ TB
- ☐ Thyroid trouble
- ☐ Tightness in shoulder muscles
- ☐ Tightness in the throat
- ☐ Twitching in face
- ☐ Ulcers

NOTE: It is understood and agreed upon the amount paid Dr. Noren-Lewis is for examination, treatment and interpretation of X-ray negatives and that X-Ray negatives will remain the property of this office, where they may be seen at any time while a patient of this office. Furthermore, I attest that all information given on this form is accurate to the best of my knowledge.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF PARENT / GUARDIAN _____ DATE _____

WHOM MAY WE THANK FOR REFERRING YOU ?_____

***UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE, PAYMENT IS EXPECTED AT TIME OF SERVICE***