STEELE CREEK CHIROPRACTIC, PLLC

CONFIDENTIAL PATIENT INFORMATION

Today's Date:_____

Name:_____ Age:_____ DOB:_____ Gender: M F

Address:_____ City:_____ State:_____ Zip:_____

Phone: (C)_____ (W)_____ (H) _____

Occupation:_____ Employer_____

Email: (for appointment reminders only, no junk)_____

Marital Status: Married/Single/Divorced/Widowed # of Children:_____

Emergency Contact Name and phone number:_____

Have you ever had previous chiropractic care? __Yes __No If yes, Dr's. Name:_____

Dr's City and State:_____

Is your present condition due to a work related or auto accident? __Y __N Circle one: Work or Auto

How did you hear about my office? _____

HEALTH INFORMATION

Main complaints: 1)_____

2)_____

3)_____

How long have you had this condition?_____

Is it Constant or Intermittent (circle one)

Is your condition getting worse? __Yes __No

Have you had similar conditions in the past? __Yes__No When?_____

What aggravates your condition?_____ Helps condition_____

Have you seen other doctors for this condition? __Yes__No List medications you are taking_____

_____

Do you have a Pacemaker?__Yes __No (WOMEN ONLY) Are you pregnant?__Yes __No

List any surgeries:_____

DO YOU SUFFER FROM

___Headaches
___Neck Pain
___Arm/Shoulder Pain
___Back Pain
___Hip/Leg Pain
___Chest Pain
___Sinus Trouble
___Heart Trouble
___ High/Low Blood Pressure
___Dizziness
___Previous Stroke/TIA
___Numbness in Arms or Legs
___Arthritis

Please check the type of care you desire so that we may be guided by your wishes when possible:

__Relief care __Relief care followed by periodic maintenance __ Maintenance care

Patient Signature:_____ Date:_____

Parent/Guardian Signature (if patient is a minor):_____ Date:_____