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

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