

**Living Well Chiropractic**  
**PATIENT INFORMATION**

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Please print clearly:

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Shipping Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

e-mail address: \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex: M/F Height \_\_\_\_\_ Weight \_\_\_\_\_

Overall health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint \_\_\_\_\_

Other complaints or problems: (use separate sheet if needed) \_\_\_\_\_

Current medications/drugs being taken: (use separate sheet if needed) \_\_\_\_\_

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

Nutritional supplements you are taking: \_\_\_\_\_

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_

=====  
Office Use Only:

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Name: \_\_\_\_\_ Date \_\_\_\_\_

**HISTORY:**

List any major illnesses (with approx. dates): \_\_\_\_\_

\_\_\_\_\_

List any surgery or operations with approx. date: \_\_\_\_\_

\_\_\_\_\_

Past Accidents or injuries: \_\_\_\_\_

\_\_\_\_\_

=====  
Marital Status: S M D W      Name of Spouse \_\_\_\_\_

Describe health of spouse: \_\_\_\_\_ Number of children if any \_\_\_\_\_

Name of Child	Age	Sex	Any physical conditions or concerns?
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other \_\_\_\_\_

Any household pets or other animals you or family members are in close contact with:

\_\_\_\_\_

What can we do to make you happier? \_\_\_\_\_

\_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE \_\_\_\_\_