N I	Date
Name	
Address	Age Birthdate
<del></del>	Sex M F Ht Weight
Primary Phone cell home Other Phone cell home	Relationship Single Married Divorced Significant Other Widowed
E Mail	Who Referred you?
Occupation	
Workplace	Emergency Contact
Work Phone	RelationshipPhone
Primary Care Provider	Practice
address	
What is the major concern that brings you here?	
What have you already done to address it?	
Is it related to a(n) Auto Accident or Work Injury? (Circle one)  Date of Accident or Injury	
Are you pregnant or trying to get pregnant?	
Please list all operations and dates	
Have you ever been advised to have any surgery or other treatm	ment which was not done?
Injuries (auto accidents, falls, etc.)	
Do you exercise? Yes No What type(s) and how frequen	ntly:
Please list all medications you are taking and how frequently:  Prescription	
Non Prescription	
Dietary Supplements (vitamins, minerals, herbs, ect.)	
Past long term medications	

Coffee Teal/Cola Tobacco Alcohol Sugar/Sweets Salt  Please circle any that apply to you. Hemophilia/ Bleeding Disorders Arthritis Diabetes High or low blood Pressure Asthma /Allergies Epilepsy/ Seizures Mental Health Problems Cancer Heart disease Ulcers Stroke Kidney disease Scarlet Fever TB Mono Alcohol or drug problems Have you ever had any of the following (fill in date) Sexually Transmitted Disease Herpes Hepatitis  The type of diet you usually follow:  Average Daily Diet Morning  I declare the above to be true and complete to the best of my knowledge. I give you permission to contact me by email and send me occasional notices. I give you permission to contact me by email and send me occasional notices. I give you permission to contact and share information with my primary care provider in regards to my care.  Signature [parent or guardian if minor) Date	Indicate if you use any of the below and ho	ow frequently you use it:	
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Please circle any that apply to you.  Hemophilia/ Bleeding Disorders  Arthritis  Diabetes  High or low blood Pressure  Asthma /Allergies  Epilepsy/ Seizures  Mental Health Problems  Cancer  Heart disease  Ulcers  Stroke  Kidney disease  Scarlet Fever  TB  Mono  Alcohol or drug problems  Have you ever had any of the following (fill in date)  Sexually Transmitted Disease  Herpes  Hepatitis  The type of diet you usually follow:  Average Daily Diet  Morning  Afternoon  Action Afternoon  Evening  I declare the above to be true and complete to the best of my knowledge.  I give you permission to contact me by email and send me occasional notices.  I give you permission to contact and share information with my primary care provider in regards to my care.			
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