

Welcome to Family First Chiropractic

Today's Date ___/___/___

Name: _____ What do you prefer to be called? _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mailing (Street) Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Email Address (for patient newsletter) _____

Date of Birth ___/___/___ Age: ___ Social Security # _____

How did you learn about our office? _____

Have you had previous Chiropractic Care? No Yes (& approximate last visit date _____)

Marital Status: Single

Married (Spouse's Name _____)

Committed (Partner's Name _____)

Divorced

Separated

Widowed

Do you have Children? No Yes

If Yes, please list names and ages: _____

What are your hobbies? _____

Occupation: _____ Name of Employer/Business: _____

Have you had a recent work injury? No Yes (& date of injury _____)

Have you had a recent auto accident? No Yes (& how long ago? _____)

Please Check Reasons for Pursuing Chiropractic Care:

I'm continuing ongoing care from another Chiropractor.

I'm interested in wellness and natural care.

I'm concerned about my health and I'm looking for answers.

I have a specific condition that concerns me.

Please describe condition or symptom: _____

I want to improve my immune function.

I have no idea why I'm here. Please take the time to explain to me what you do.

(Continue Form on Other Side)

In order for us to understand your current level of health, please check any of the following Body Signals which you have or have had previously:

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Posture Imbalance | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Short Leg/Orthotics | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Ear infection | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Menopausal Symptoms | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Headache |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma | |

Check the following conditions YOU have or have had:
Circle the following conditions common to FAMILY MEMBERS:

- | | | | | |
|---|---------------------------------------|------------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Hyper/Hypothyroidism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> AIDS | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease | | | |

It is important to our patients as well as ourselves that we have the same health objectives concerning Chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, Chiropractic care on this basis.

Signature: _____

Date: ___/___/___