Complete Chiropractic

NEW PATIENT INFORMATION

Weight Loss ☐ or Quit Smoking ☐

Last Name: ___________________________ First Name:_____________________ MI: ______________

Street: ______________________________ City:_________________________ State: ________________

Zip Code: _________________ Home Phone:_____________________ Work Phone: ___________________

Cell Phone: ____________________ Date of Birth: _______________ Height: ___________Weight________

Sex: Male _______ Female _______ Current Age:____________ E-mail address:_______________________

Marital Status: Married __________ Single __________ Widowed__________ Divorced ________________

Blood Pressure_____/_______ Medical Allergies____

Have you smoked? Y / N Still Smoke? Y / N if yes, packs per day? _________________________________

Medication Name	Milligrams	Dosage per day

Referred by: ________________________________

HEALTH HISTORY (Please circle all that apply)

Neck Pain	Rheumatoid Arthritis	Epilepsy
Back Pain	Pinched Nerve	Heart Disease
Arm Pain	AIDS/HIV	Hepatitis
Leg Pain	Allergies	Multiple Sclerosis
Degenerative Disc Disease	Bleeding Disorder	Pacemaker
Herniated Disc	Cancer	Psychiatric Care
Headaches	Chemical Dependency	Tuberculosis
Osteoporosis	Depression	Stroke
Arthritis	Emphysema	

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including AuriculoStaple treatment. I understand that I am under the care and supervision of Dr. Bob Robertson, Jr. DC and it's the responsibility of the staff to carry out the instructions of such physician.

I hereby have been informed of the potential risk of AuriculoStaple and give my complete consent to the treatment. I have also been informed of the time frame of after care for this procedure and will follow those instructions given by Dr. Robertson. I also state that I am not in my first trimester of pregnancy.

Patient Printed Name __________________________Patient Signature_________________________
Witness_____________________________________Date___________________________________