# Mitchell Family Chiropractic

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NEW PATIENT INFORMATION FORM -Please Print Clearly- Page 1

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:

NEW PATIENT INFORMATION FORM- Page 2

Name: _____ Date _____

HISTORY: List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date: _____

_____

Past Accidents or injuries: _____

_____

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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?

_____ ____ M/F _____

_____

_____ ____ M/F _____

_____ ____ M/F _____

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 _____