Peninsula Chiropractic Center

[redacted]

331 Kentucky St Sturgeon Bay, WI 54235 Telephone 920-743-6919 Fax 920-746-0619

NAME _____ DATE _____

CELL PHONE _____ CELL PHONE CARRIER _____

EMAIL _____ SECONDARY PHONE _____

ADDRESS _____ CITY _____ ZIP CODE _____

AGE _____ DATE OF BIRTH _____ MARITAL STATUS : S M SEP W D

NUMBER OF CHILDREN ____ AGES _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ OFFICE PHONE _____

PATIENT'S NEAREST RELATIVE _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

HAVE YOU EVER SUFFERED FROM:

(CIRCLE YES OR NO)

1. DIZZINESS Y N
2. BACKACHES Y N
3. HEART TROUBLE Y N
4. DIABETES Y N
5. TUBERCULOSIS Y N
6. DIGESTIVE DISORDERS Y N
7. ARTHRITIS Y N
8. HEADACHES Y N
9. NUMBNESS Y N
10. ASTHMA Y N
11. NEURITIS Y N
12. PROSTATE PROBLEMS Y N
13. NERVOUSNESS Y N
14. SINUS TROUBLE Y N
15. ANEMIA Y N
16. RHEUMATIC FEVER Y N
17. CANCER Y N
18. SERIOUS ILLNESS Y N

WHAT TYPE OF PAIN ARE YOU CURRENTLY SUFFERING? _____

OTHER DOCTORS YOU HAVE SEEN FOR THIS CONDITION? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC TREATMENT? Y N DOCTOR _____

CURRENT MEDICAL DOCTOR _____ DATE OF LAST PHYSICAL _____

CURRENT MEDICATIONS _____

_____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE PAST YEAR? Y N DESCRIBE _____

WHAT SURGERIES HAVE YOU HAD AND WHEN? _____

_____

ARE YOU PREGNANT?

(Any additional information you wish to provide can be written on the back)