INITIAL CHIROPRACTIC PATIENT INFORMATION

1. Please complete this form and fax or mail it to the office. If you are unable to, please bring it with you on your first visit.
2. Please also have all x-ray, MRI, CAT scan, EMG and other relevant reports (Emergency room, specialist, etc) faxed to the office

Fax to: 302-999-9826 Mail: 507 S. Maryland Ave. Wilmington, DE 19804

Name_____ Date_____

Home Phone_____ Work Phone_____
Cell Phone_____

Address_____

City, State, Zip_____ Email Address_____

Birthdate_____ Age_____ SS#_____

Occupation_____ Employer_____ ( )FT ( ) PT

Marital Status: M W D S Engaged Spouse's/Fiancé's name_____ No. of Children____

Most patients are referred to our office from a family member or friend. What made you decide to visit our office? ❑Friend or Family Member Name: _____
❑Drove by our office ❑Magazine ❑Insurance Co. ❑Email ❑Other_____

How many times have you visited a Doctor of Chiropractic in your lifetime, where and when?_____
_____ ❑I was receiving monthly wellness chiropractic care. ❑I never visited a chiropractor before today.

Please provide the date and location of your previous test(s):

X-Rays: ❑None ❑Yes: Date:_____ For:_____
Where they were taken: _____

MRI: ❑None ❑Yes: Date:_____ For:_____
Where they were taken: _____

CAT Scan: ❑None ❑Yes: Date:_____ For:_____
Where they were taken: _____

Other:_____ Date:_____ For:_____
Where they were taken: _____

Other healthcare professionals who you have seen for your present concern(s):

❑Doctor/❑Therapist:_____When:_____ ❑Still under their care
Diagnosis and Treatments_____

❑Doctor/❑Therapist:_____When:_____ ❑Still under their care
Diagnosis and Treatments_____

❑Doctor/❑Therapist:_____When:_____ ❑Still under their care
Diagnosis and Treatments_____

_____ _____
Patient Name (printed) Patient Signature

_____ _____
Legal Guardian Name (printed) Legal Guardian Signature

Additional Patient Information

In order to maintain records that comply with federal standards, please answer the following questions:

Preferred Language?

□ English □ Spanish □ Other_____

Race?

□ I do not wish to provide this information.
□ White
□ Black or African American
□ American Indian or Alaska Native
□ Asian
□ Native Hawaiian or Other Pacific Islander
□ Other _____

Ethnicity?

□ I do not wish to provide this information.
□ Hispanic or Latino
□ Non-Hispanic or Non-Latino
□ Other _____

Smoking Status?

□ Current every day smoker □ Current some day smoker
□ Former smoker □ Never smoked

Do you have any medication allergies?

□ No known medication allergies
□ Yes. What? _____
_____

Are you currently taking any medications?

□ Not currently prescribed any medications
□ Yes…

What? _____ _____ mg □tablet □capsule □chewable □liquid

What? _____ _____ mg □tablet □capsule □chewable □liquid

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What? _____ _____ mg □tablet □capsule □chewable □liquid

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