INITIAL CHIROPRACTIC PATIENT INFORMATION

1. Please print and complete this form
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 Email to: info@rosenthalchiropractic.com 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____

1. **Most patients are referred to our office from a caring family member or friend. What made you decide to visit our office?** ❑Friend or Family Member Name: ______________________________ ❑Drove by our office ❑Magazine ❑Presentation ❑Health Fair ❑Insurance Co. ❑Email ❑Other__________________________

2. **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.

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

   X-Rays: ❑No ❑Yes: Date:______________ For:_________________________________
   Where they were taken: ____

   MRI: ❑No ❑Yes: Date:______________ For:_________________________________
   Where they were taken: ____

   CAT Scan: ❑No ❑Yes: Date:______________ For:_________________________________
   Where they were taken: ____

   Other:____________ Date:______________ For:_________________________________
   Where they were taken: ____

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

   ❑Doctor/❑Therapist:____________________________When:____________
   Diagnosis and Treatments____

   ❑Doctor/❑Therapist:____________________________When:____________
   Diagnosis and Treatments____

5. **Name of Primary Care Physician (PCP)**:____
   (We may send a report to your Primary Care Physician- please inform us if you would like it sent to an additional Doctor)

6. **Vitamins/Supplements you are currently taking:**
   ( ) multivitamin ( ) fish oil ( ) other(s):____

___________________________ ___________________________

Patient Name (printed) Patient Signature

___________________________ ___________________________

Legal Guardian Name (printed) Legal Guardian Signature

____

Date

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…

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