## SANTIN CHIROPRACTIC CONFIDENTIAL PATIENT INTRODUCTION

**Name**_____**Date**_____ _____

**Address**_____**City**_____**Postal Code**_____

**Date of Birth**_____ **Age** _____ **Occupation** _____

**Telephone: Res** _____**Bus**_____**Cell**_____

**E-mail address:**_____ **# of Children:**_____

**Medical Doctor:** _____**Which one of our patients referred you:**_____

**Major Complaint** _____**For How long?** _____

**Is it getting: Worse**_____ **Constant**_____ **Comes/Goes**_____ **Better**_____

**Other Complaints:** _____ **For How long?** _____

**Previous diagnosis and treatment for present condition**_____

**List surgeries, hospitalizations, injuries and/or accidents:** _____

_____

**Are you on any medications or supplements? ____N___Y List:** _____

**Have you had previous Chiropractic Care? ___N___Y When?** _____ **Who?** _____

**FAMILY HEALTH INFORMATION:** Many health problems are hereditary. This information about your family members (ie: mom, Dad, brothers, and sisters) will give us a better picture of your total health. Please list any health problems. (Incl. arthritis, cancer, heart disease, diabetes)

| NAME | RELATIONSHIP | PAST AND PRESENT HEALTH PROBLEMS |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**PHYSICAL ACTIVITY:** How many times per week do you exercise___0___1-2 ___3-5___>5

**Type and duration**_____

**NUTRITIONAL:** Personal satisfaction with diet: ___Highly satisfied ____Satisfied ____Unsatisfied ____Dissatisfied

Do you Smoke? ___N___Y How many per day?____ Coffee-Daily __1-2 cups __3-4cups ___More

**CHECK THE CONDITIONS FOR WHICH YOU HAVE BEEN TREATED**

____Alcoholism ___Diabetes ___Thyroid ____Rheumatic Fever ____Tuberculosis ____Anemia ____Diphtheria ___Mumps
____Ulcers ____Heart Disease _____Appendicitis ____Eczema ___Polio ____Measles ____Arthritis ____Arteriosclerosis
____Emphysema ____Multiple Sclerosis ____Cancer___Scarlet Fever ____Cold Sores ____Epilepsy ____Pneumonia
_____Stroke ____Venereal Disease ____Attention Deficit Disorder ____Allergies ____High Blood Pressure ____Migraines
_____ Asthma _____Glandular Fever ____Infertility

**DATE OF LAST:**

Physical examination (with M.D) _____

Spinal X-ray_____

**FOR WOMEN ONLY: When did your last period start? _____ Are you pregnant? __N__Y__maybe**