CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date of Birth: ____/____/____

Age: _____ □ Male □ Female Hand dominance: □ Right □ Left □ Ambidextrous

Address:_____

City, State, Zip Code: _____ # of Children: _____

Marital Status: Single □ Married □ Domestic Partnership □ Widowed □ Divorced □

Social Security #: _____ Partner's Name: _____
Contact preference: Home Phone □ Cell Phone □ Email □ Work Phone □

Home Phone # (____)_____Cell Phone # :(____)_____ Email:_____

Employer/Occupation: _____ Work#:(_____)_____

Emergency Contact: _____ Phone#:(_____)_____

How were you referred to this office? _____

Have you ever had chiropractic care before? □ Yes □ No If yes, when and by whom? _____
Who is your primary care physician or group/clinic? _____
May we contact your physician if necessary? □ Yes □ No Doctor's phone #: _____
When was your last complete physical exam? _____
Have you had any prior serious accidents or injuries (i.e., car accidents, bad falls, broken bones)?
□ Yes □ No If yes, please list by date:

_____

_____

Please list any major medical conditions, surgeries, or hospitalizations by date:

_____

_____

Please list **(1)** all medications and supplements you are currently taking, **(2)** the dosage (mg), and **(3)** what they are for:

_____

_____

_____

Please list **(1)** any medical conditions that are known in your family history and **(2)** who has/had the condition.
(for example: heart/vascular disease, stroke, diabetes, cancer, bone or joint disease, etc)

_____

_____

Do you have any allergies? □ environmental □ seasonal □ food □ medication □ other □ none

Please list all medication allergies: _____

I certify that the above information is true and correct to the best of my knowledge.

Print Patient's Name: _____

Signature: _____ **Date:** ____/____/____

(Patient, Parent or Legal Guardian)

Remington Chiropractic Pamela F. Wells, D.C.
685 E. Remington Drive, Suite C, Sunnyvale, CA 94087 Phone: (408) 737-0330 Fax: (408)737-0692

Name: _____ **Date:** ____/____/____

Please list your chief complaints in order of severity:

1. _____

When did it begin? _____

2. _____

When did it begin? _____

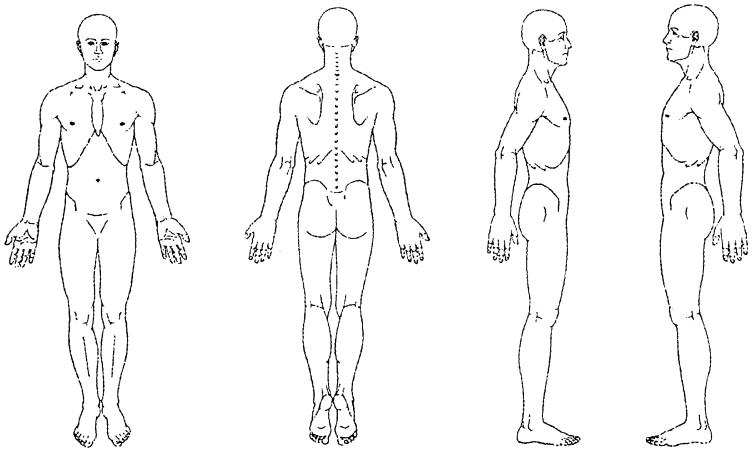
3. _____

When did it begin? _____

Are any of these complaints work related? ☐ Yes ☐ No
Due to a recent auto accident? ☐ Yes ☐ No

Please use the diagrams below to indicate the location and type of pain you are experiencing at this time.

Key
A: Ache
B: Burning
D: Dull Pain
M: Muscle Spasm
N: Numbness
P: Pins and Needles
S: Sharp Pain
T: Tingling



Please list any doctors consulted for the above conditions: _____
_____

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 smoker

Doctor's Notes:

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