Hartman Chiropractic Centre

NEW PATIENT INFORMATION FORM

NAME_____ Date_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____ EMAIL_____

HOME PHONE ( ) _____ WORK / CELL PHONE ( ) _____ AGE_____

HEIGHT_____ WEIGHT_____ BLOOD TYPE (if known)_____ DATE OF BIRTH_____

OCCUPATION_____ EMPLOYER_____

HOW DID YOU HEAR ABOUT NUTRITION TESTING? _____

EMERGENCY CONTACT_____ PHONE_____

OVERALL HEALTH (circle one): EXCELLENT / GOOD / FAIR / POOR / OTHER_____

CHIEF COMPLAINT (reason you are here) _____

PREVIOUS TREATMENTS FOR THIS COMPLAINT_____

OTHER COMPLAINTS OR PROBLEMS: _____

HAVE YOU GAINED OR LOST MORE THAN 20LBS IN THE LAST YEAR? YES_____ NO _____
DO YOU SMOKE, OR DRINK COFFEE OR SODA, OR ALCOHOL? (if yes please indicate how much)
ALCOHOL _____ CIGARETTES _____ COFFEE/SODA_____

PLEASE LIST ANY MEDICATIONS/DRUGS YOU HAVE TAKEN WITHIN THE LAST YEAR? _____
_____
_____

LIST ANY OVER –THE-COUNTER MEDICATIONS OR VITAMIN SUPPLEMENTS YOU TAKE ON A REGULAR BASIS?_____
_____
_____

DO YOU HAVE ANY SPECIAL DIETARY HABITS? YES_____ NO _____ IF YES, PLEASE SPECIFY:_____
_____

PLEASE LIST THE FORMS AND FREQUENCY OF REGULAR EXERCISE (EX; SWIMMING, CYCLING, RUNNING, ETC)
EXERCISE: _____ HRS/WEEK _____
_____ _____

HAVE YOU EVER HAD ANY SURGERY? YES_____ NO _____ IF YES, PLEASE LIST BELOW:
TYPE OF SURGERY _____ DATE_____
_____ DATE_____
_____ DATE_____

LIST ANY MAJOR ILLNESSES (with approx dates)_____
_____

Past Accidents or Injuries: _____
_____

Do you have or Have you ever had (check all that apply):

_____ Anemia
_____ Appendicitis
_____ Arthritis
_____ Cancer (specify)_____
_____ Chronic Bronchitis
_____ Chronic Headaches
_____ Colitis
_____ Diabetes
_____ Endometriosis
_____ Ovarian Cysts
_____ Gall Bladder Problems
_____ Heart Disease
_____ Hepatitis
_____ Herpes, Simplex
_____ Fever Blisters, Cold Sores
_____ High Blood Pressure
_____ Hysterectomy (Ovaries Removed? Yes_____ No_____)
_____ Kidney Infection
_____ Liver Problems
_____ Loss of Balance
_____ Neurological Problems
_____ Parasitic Infection
_____ Pneumonia
_____ Seizures
_____ Thyroid Problems
_____ Ulcers

LIST ANY ALLERGIES_____
_____

Have you ever been treated for cancer? Yes_____ No _____ If yes, explain therapy:_____
_____
_____

Please use this space for any other pertinent information you want to include to assist us to most effectively help you reach your health goals: _____
_____
_____
_____
_____

Marital Status: S M D W name of Spouse:_____
Describe health of Spouse_____ Number of children_____

Name of child	age	sex	any physical conditions or concerns?
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Any family history of serious illness (circle those that apply: Cancer / Diabetes / heart / other_____
_____

Any household pets or other animals you or family members are in close contact with:_____
_____

What can we do to make you happier?_____
_____
_____

SIGNED: _____ DATE: _____