Patient Information

Name:_____

Medical/Drug Information:
Please list current **MEDICATIONS** or provide the office with a copy of your medication list

_____ _____

_____ _____

Please list any know **MEDICATION ALLERGIES** or provide the office with a copy of your medication allergy list.

_____ _____

_____ _____

Please list any know **ALLERGIES** (Pollen/seasonal, peanuts, etc)

_____ _____

_____ _____

SMOKING STATUS:(Circle One)
Current every day smoker: 1 2 3 (packs per day) Former Smoker
Never Smoker

Height:_____ Weight:_____

RACE:(Circle One)
American Indian Asian African American White Pacific Islander Decline

ETHNICITY:(Circle One)
Hispanic or Latino Not Hispanic or Latino Decline

PCP Name:_____
_____Yes, I would like you to advise my PCP of my chiropractic care.
_____No, I do not want you to advise my PCP of my chiropractic care.

Office Use: BP:_____/_____