Patient Information

Please list current MEDICATIONS or provide the office with a copy of your medication 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) Please list any know ALLERGIES (Pollen/seasonal, peanuts, etc)	Name:	
Please list any know MEDICATION ALLERGIES or provide the office with a copy of your nedication allergy list. Please list any know ALLERGIES (Pollen/seasonal, peanuts, etc) IMOKING STATUS:(Circle One) Current every day smoker: 1 2 3 (packs per day) Former Smoker Reight: Weight:	Medical/Drug Information:	
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MOKING STATUS:(Circle One) Current every day smoker: 1 2 3 (packs per day) Never Smoker Height: Weight:		
RACE:(Circle One)	SMOKING STATUS:(Circle One) Current every day smoker: 1 2 3 (packs per day Never Smoker	
·	Height: Weight:	
	RACE:(Circle One) American Indian Asian African American	White Pacific Islander Decline
THNICITY:(Circle One) Hispanic or Latino Not Hispanic or Latino Decline	ETHNICITY:(Circle One)	
PCP Name:	PCP Name:	
Yes, I would like you to advise my PCP of my chiropractic care.	Yes, I would like you to advise my PCP o	of my chiropractic care.
No, I do not want you to advise my PCP of my chiropractic care.	No, I do not want you to advise my PCP	of my chiropractic care.