

# Crocker Chiropractic Center, LLC

## Patient Information

### Personal Information:

Mr.  Mrs.  Miss Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
SS#: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Birth date: \_\_/\_\_/\_\_ Drivers License #: \_\_\_\_\_ Marital Status: M D S W  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_  
Hours of Employment: (M)\_\_\_\_\_ (T)\_\_\_\_\_ (W)\_\_\_\_\_ (T)\_\_\_\_\_ (F)\_\_\_\_\_ (Sa)\_\_\_\_\_ (Su)\_\_\_\_\_  
Nearest Relative: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

HOW DID YOU HERE ABOUT US? \_\_\_\_\_

### Reason for your Visit:

Have you been to this clinic before?  Yes  No Purpose of this appointment: \_\_\_\_\_  
Reason for your visit is a result of (please circle): Work Injury Auto Accident Trauma Chronic Problem Other  
Date of accident / injury, or when condition began: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Have you been treated by another doctor for this condition?  Yes  No  
If yes, what doctor / health care facility: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Medical Care Information:

Do you have a family doctor?:  Yes  No Name of Doctor: \_\_\_\_\_  
Have you ever been to a chiropractor?  Yes  No Name of chiropractor: \_\_\_\_\_  
Date of last visit: \_\_\_\_\_  
Have you had surgeries in the last 5 years?  Yes  No  
Please List surgeries and dates: \_\_\_\_\_  
Please list any medications you are taking: \_\_\_\_\_

### Present Illness / Conditions:

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS                        | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Bone fracture               | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Cirrhosis/hepatitis | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Dislocated joints      |
| <input type="checkbox"/> Diverticulitis              | <input type="checkbox"/> Hay fever           | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> HIV/ARC            | <input type="checkbox"/> Kidney trouble         |
| <input type="checkbox"/> Multiple Sclerosis          | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Prostate Trouble    | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Scoliosis              |
| <input type="checkbox"/> Sinus trouble               | <input type="checkbox"/> Spinal disc disease | <input type="checkbox"/> Thyroid trouble     | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Ulcer                  |
| <input type="checkbox"/> Polio                       | <input type="checkbox"/> STD's               | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Mental/Emotional difficulty | <input type="checkbox"/> High blood pressure |  |   |   |

