**PATIENT INFORMATION**
**(Please Print)** **Date: _____**

Patient's Name: _____
(Last) (First) (MI)

Local Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Cell #: _____ Home #: _____ E-Mail _____

Age: _____ Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____ Minor ____

If Minor, Responsible Party: _____

Out of State Address and Phone: _____

Employer's Name: _____

Employer's Address: _____

Business Phone: (_____) _____-_____ Occupation _____

Spouse's Name: _____ Spouse's Employer: _____

Employer's Address: _____

Business Phone: (____) _____-_____ Occupation: _____

Person to Notify in Case of Emergency, other than Spouse: _____ Phone: _____

Referred By: _____

Family Physician: _____

Medication / Supplements: _____

_____

Allergies: _____

Reason for Visit: _____

Is this related to an Automobile Accident? _____ Is this a Worker's Compensation Injury? _____

Please list past surgeries/procedures: _____

Do you smoke? Yes ____ No ____ If Yes, how much? _____

Do you drink coffee / black tea? If Yes, how much? _____

Do you use alcohol? Yes ____ No ____ If Yes, how much _____

Do you Exercise? If Yes, how often? _____