ADDITIONAL HEALTH AND GENERAL INFORMATION

Patient Name_____ SS#_____

Cell Phone_____

Email (for communication with health updates/newsletters)_____

Marital Status:
❑Married ❑Single ❑Widowed ❑Divorce

Number of Children_____

What experience do you have with chiropractic care?_____

What other treatment and/or remedies have you previously tried for this condition?

_____

Do you normally exercise? ❑Yes ❑No

If yes, what activities and how often?_____

Do you smoke? ❑Yes ❑No If yes, how many cigarettes per day?_____

Do you drink alcohol? ❑Yes ❑No If yes, how many drinks per week?_____

EMERGENCY CONTACT:

Name_____Relationship_____

Home Phone_____ Work Phone_____

I attest that the information above is true and accurate to the best of my knowledge:

Signature: _____**Date:**_____