

SWIESZ FAMILY CHIROPRACTIC, LLC



CHANGING THE WORLD ONE SPINE AT A TIME

CHIROPRACTIC REGISTRATION AND HEALTH HISTORY

Patient Information:

Name: _____ Date: _____
Address: _____ City: _____
State/Zip: _____ DOB _____
Home phone: _____ Cell _____
Work phone: _____ SS# _____
Email: _____ Marital Status: M D S W
Spouse's Name: _____
Names and ages of Children _____
Employer: _____ Occupation _____
Name of insurance company: _____
Previous Chiropractic Care: Y N If yes, date of last visit _____
Hobbies or Interests _____

Health History

Please list your reasons for seeking chiropractic care:

Please Circle if you have or have had any of the following conditions:

AIDS/HIV	Diabetes	Headaches	Stroke
Anemia	Emphysema	MS	Hypo/Hyper thyroid
Arthritis	Epilepsy	Osteoporosis	
Asthma	Gout	Polio	Ulcers
Bleeding Disorders	Heart Disease	Prostate	
Cancer _____	Hepatitis	Rheumatoid arthritis	

Other: _____

Surgeries: _____

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Medications: _____

Exercise

Please Circle what best describes your level and Type of exercise:

None Moderate Daily Heavy

Walking Jogging Weight Training Swimming

Yoga Pilates Bike Riding Aerobics

Other: _____

Habits

Smoking Yes No Quit Packs per Day _____

Alcohol Yes No Quit Drinks per week _____

Coffee Yes No Quit Cups per week _____

Energy Drinks Yes No Quit Cans Per week _____

Chewing Tobacco Yes No Quit Amount per week _____

Fast Food Meals Yes No Quit Meals per week _____

Recreational Drugs Yes No Quit Times Per Week _____

Do you currently take Supplements? Y N

Please List _____

Do you wear orthotics? Y N

If Yes, how long have you had them. _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature

Date