

LEXINGTON CHIROPRACTIC & WELLNESS, P.A. WARMLY WELCOMES YOU!

Patient Information		
First Name:	Middle:	Last:
Gender: <input type="radio"/> F <input type="radio"/> M	Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed	
Street:	City:	
State:	Zip Code:	
Date of Birth: Month / Day / Year	Today's Date:	/ /
Home Telephone:		
Work Telephone:		
Cell Telephone:		
Email Address:		

Emergency Contact Information
Emergency Contact Name:
Emergency Telephone:
Relationship:

Employer Information	
Employer Name:	
Description of Occupation:	
Street:	City:
State:	Zip Code:

How did you hear about our office?

Consent for Treatment

The information that you provide concerning your health status and medical history are of great importance so as to determine the best possible treatment options available. I certify the information I have provided is accurate and complete to the best of my knowledge. Furthermore, I hereby authorize Sara Tussey, D.C., to perform examinations and to administer treatment as necessary.

Signature: _____

Date: _____

Signature of Parent: _____
(if under age of 18)

Relationship to Minor: _____

Name: _____

Date: _____

Medical History			
<input type="checkbox"/> Allergies (Seasonal)	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Arthritis (DJD, Rheumatoid)	<input type="checkbox"/> Hypertension (High Blood Pressure)
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraine Headache
<input type="checkbox"/> Kidney Disease/Stones	<input type="checkbox"/> Bowel Irregularity (Constipation/Diarrhea)	<input type="checkbox"/> COPD	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Diabetes Mellitus (Type I)	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Gout	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Diabetes Mellitus (Type II)	<input type="checkbox"/> Asthma
<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Gallbladder Disease/Stones	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Headache	<input type="checkbox"/> Gastrointestinal Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Menstrual Irregularity
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Psychological Disorder
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hyperlipidemia or High Cholesterol	<input type="checkbox"/> Other:

Family History	Relationship to you	Relationship
<input type="checkbox"/> Cancer		<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Gout		<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Asthma		<input type="checkbox"/> Stroke

Latest Examination(s)	Date	Reason/Result	Practitioner's Name
<input type="checkbox"/> Chiropractic :			
<input type="checkbox"/> Physical examination :			
<input type="checkbox"/> X-Ray examination :			
<input type="checkbox"/> Blood tests :			
<input type="checkbox"/> Urine tests :			

Trauma History	Date	Description
<input type="checkbox"/> Hospitalizations		
<input type="checkbox"/> Surgeries		
<input type="checkbox"/> Fractures/Dislocations		
<input type="checkbox"/> Trauma		
<input type="checkbox"/> Other		

Work Activity	Exercise	Social History
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol use # drinks/day:
<input type="checkbox"/> Moderate	<input type="checkbox"/> Occasional	<input type="checkbox"/> Smoking # packs/day:
<input type="checkbox"/> Daily	<input type="checkbox"/> Moderate	<input type="checkbox"/> Recreational drug use
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy	<input type="checkbox"/> Significant weight change in past 6 months
Type:	Type:	<input type="checkbox"/> High stress level
		<input type="checkbox"/> Poor sleep quality

Medication
<input type="checkbox"/> Currently taking medication. Please indicate type and amount:

