WELCOME TO NORMAN FAMILY CHIROPRACTIC & WELLNESS

ADULT FORM

Name:	**Age:**	**Date of Birth:**
Address: (Street, City, State & Zip)		
Phone: (Home)	**(Work)**	**(Cell)**
Email Address:	**Employer:**	
Sex: □ Male □ Female	**Marital Status: □ Single □ Married □ Widowed □ Divorced**	
Spouse's Name:	**Spouse's Occupation:**	
How many children do you have?		
Names & Ages of Children:		
How did you hear about Dr. Norman?		
Have you ever consulted a Doctor of Chiropractic?		
If yes: Who?	**When?**	**How long were you under care?**
Did you receive: X-rays (when)?	**MRI (when)?**	

Please list your occupation and describe what type of work you do daily:

Please describe what brought you into our office today:

The statements made on this form are accurate to the best of my recollection, and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered.

X _____ _____

Signature **Date**

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Do you now, or have you ever suffered from:

□ Dizziness	□ Heart trouble	□ Diabetes	□ Lung problems
□ Asthma	□ High blood pressure	□ Neuritis	□ Digestive disorder
□ Heart burn	□ Headaches	□ Arthritis	□ Sinus trouble
□ Cancer	□ Nervousness	□ Anemia	□ Trouble Sleeping
□ Low Energy	□ Poor Circulation	□ Anxiety	□ Tingling in hands/feet
□ Allergies	□ Tire easily	□ TB	□ Numbness in hands/feet
□ Irritability	□ Depression	□ Tumor	□ Menstrual pain or difficulties

Please list any other health concerns you have at this time:

_____

_____

Physical Stressors

List any accidents or injuries:
List childhood injuries:
List any broken bones:
List any surgeries:
List any other medical procedures:
Do you do any physical activity on a daily basis? If yes, what type?

Chemical Stressors

List any and all Prescriptions and OTC drugs:
Do you drink coffee or caffeinated beverages? How often?
Do you smoke or chew tobacco? Do you drink alcohol? How often?

Emotional Stressors:

Have you had any strong emotional stressors recently or in the past?