

Sanctuary Chiropractic & Acupuncture Center

(Please Print)

GENERAL INFORMATION:

DATE: _____

PATIENT LAST NAME _____ FIRST NAME _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ NO. OF CHILDREN _____
SEX: M ___ F ___ MARRIED ___ SINGLE ___ WIDOWED ___ DIVORCED ___ D.O. B. _____ AGE _____
SOCIAL SECURITY NO. _____ E-MAIL: _____
OCCUPATION _____ FULL TIME ___ PART TIME ___ RETIRED ___ OTHER ___
PLACE OF EMPLOYMENT _____
WHOM MAY WE THANK FOR REFERRING YOU? _____

SYMPTOMS/ HEALTH CONCERNS:

1. _____
2. _____
3. _____

PLEASE CHECK ALL SERVICES YOU MAY WANT:

___ CHIROPRACTIC ___ ACUPUNCTURE ___ MASSAGE THERAPY
___ NUTRITION EVALUATION ___ NEURO EMOTIONAL ___ HORMONE EVALUATION
___ X-RAYS ___ MEDICAL EXAM ___ BLOOD WORK ___ GENERAL EVALUATION

HAVE YOU BEEN INVOLVED IN A CAR ACCIDENT? YES NO DOA _____
HAVE YOU HAD RECENT X-RAYS? YES NO
HAVE YOU HAD A RECENT MEDICAL EXAM? YES NO
HAVE YOU HAD ANY SURGERY? YES NO
DO YOU HAVE ANY METAL, PINS, RODS, SCREWS, OR STAPLES? YES NO
HAVE YOU HAD CHIROPRACTIC CARE BEFORE? YES NO
HAVE YOU HAD ACUPUNCTURE BEFORE? YES NO
IS THERE ANY REASON YOU FEEL YOU CAN'T BE ADJUSTED? YES NO
DO YOU HAVE HEALTH INSURANCE? YES NO

NAME OF HEALTH INSURANCE _____
IF INVOLVED IN A CAR ACCIDENT :
NAME OF ATTORNEY _____ PHONE _____

THANK YOU FOR FILLING OUT THIS FORM. IT WILL HELP US HELP YOU.
Our mission at Sanctuary Chiropractic and Acupuncture Center is to help you live an active, healthy life. Our request is that you refer your family, friends and neighbors so they too may enjoy abundant health, naturally. We are home of the "WOW" Chiropractic and Acupuncture experience. Tell others we care.

PATIENTS SIGNATURE _____ DATE _____