

WENGER CHIROPRACTIC GROUP

Today's Date: _____

Name: _____

Date of Birth: _____

Email: _____

Height: _____ Weight: _____ BP _____ / _____

List your Allergies: None

- Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Mold Ragweed/Pollen
- Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other _____

List any Surgeries: None

- Back/Neck Brain Elbow Foot Gynecological Hip Knee Shoulder Wrist
- Other _____

List your Medical History Conditions: None

- Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain
- Depression Diabetes Dizziness Elbow Pain Eye/Vision Problems Fainting Fatigue
- Foot Pain Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis
- High Blood Pressure Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain
- Menstrual Problems Mid Back Pain Minor Heart Problems Neck Pain Neurological Problems
- Pacemaker Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury
- Sprain/Strain Stroke/Heart Attack Other _____

List Medications you are taking: _____

List Medications you are Allergic to: _____

List your Family Medical History: (Example: Grandmother-high blood pressure, father-heart attack)

Have you had any auto or other accidents? No Yes

Describe: _____

Race (Please Choose One) American Indian Alaska Native Asian
 African American (Black) Native Hawaiian or Other Pacific Caucasian (White)

Ethnicity (Please Choose One) Hispanic or Latino Not Hispanic or Latino

Primary Language: English(Ingles) Spanish(Espanol) Other(Please List) _____

Do you smoke? No Yes - Daily Some Days Former smoker? No Yes

Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes - what forms and how often? _____