Latimer Chiropractic Total Wellness Center

WELLNESS VISIT INFORMATION FORM-----To help us better serve you

WELCOME

Please print clearly:

Name:_____ **Date:**_____
Address:_____ **Apt:**_____
City:_____ **State:** _____ **Zip:**_____
Home Phone: _____ **Work Phone:**_____

Email address:_____
REFERRED BY:_____

Occupation:_____ **Employer** _____
Date of Birth_____ **Age**_____ **Sex: M/F** **Height:**____ **Weight:**____
Marital Status: S M D W Name of Spouse_____ Number of Children _____

Primary Concerns-symptoms-issues? (AND WHEN DID THEY BEGIN?) ie: fatigue,weight, allergies, digestion, immune, concentration, skin, infections, use back of page if more room needed

Physicians or other health care professional? and date of last visit)_____

Medications, dose and their purpose_____

Nutritional supplements you are taking:_____

Do you use? If yes, indicate how much:
Cigarettes _____ Coffee_____ Alcohol_____Recreational drugs?_____

How much water—other liquids do you drink? Just with meals or all day?

_____

Major illnesses (with approx. dates)_____

_____

_____

_____

Surgery or operations (with approx. dates)_____

_____

_____

_____

Past accidents or injuries and scars:_____

Family history of serious illness (circle which apply): Cancer /Diabetes / Heart /Digestive/ Other

_____

_____

_____

Household pets or other animals:_____

Use of electronic devices frequently_____

Pt SIGNED:_____ **DATE:**_____

PGL 8-2013