Chris Harrison Chiropractic Office

1025 Montgomery Highway Suite #102, Vestavia Hills, Alabama 35216
205-823-5931 Fax: 205-823-1534
Website: drchrisharrison.com email: clhdc41@gmail.com

Date_____ Patient Number (we will write this in for you) #_____

Name_____

Address_____
Number Street City State Zip

Phone_____
Home Work Cell Other

E-mail_____
Home Work

Date of Birth_____ Place of Birth_____

Sex____ Height_____ Weight_____ Occupation_____

Employer_____ Work Address_____

Marital Status_____ Spouse's name_____

Number of children_____ Ages of Children_____

In case of emergency, we should call_____
Relationship to you_____ Phone_____

Who referred you or how were you referred to this office?_____

_____

Have you received chiropractic care previously?_____

Please tell us how we may be of help to you_____

_____

_____

_____

Our policy is payment in full at the time service is rendered. Thank you for considering our office for your health care and welcome to our office.

Please describe your general state of health (how you really feel and act most of the time).

_____
_____
_____
_____

Please list all serious diseases and conditions that you have had. Please list in chronological order with the year noted first.

The year it started The disease or condition

1._____
2._____
3._____
4._____
5._____

Please list all diseases and conditions that run in your family. This should include your great grandparents, grandparents, parents, brother and sisters, aunts and uncles, and children in your blood line.

Disease or Condition Family Member

1._____
2._____
3._____
4._____
5._____

Please list all surgical operations that you have had. Start with the oldest one first.

Year (oldest first) Surgical Procedure Performed Reason for Surgery

1._____
2._____
3._____
4._____
5._____
6._____

Please list all major trauma and traumatic events in your life. These would be events that affected you deeply. These could be PHYSICAL events such as accidents, near drowning, serious burns, etc. CHEMICAL events such as poisoning, drug and allergic reactions. EMOTIONAL events such as deaths, divorce, rape, abuse, etc. List in Chronological order.

Date (oldest first) Traumatic Event

1._____
2._____
3._____
4._____
5._____

Please list all drugs and medications that you are presently taking. These should include: prescription drugs, over-the-counter medications, and homeopathic medicines. Also include recreational drugs but do not include nutritional supplements.

Date started Drug or medication Dosage and frequency Reason for taking

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Do you smoke? Yes___ No___ Do you use other tobacco products? Yes____ No____
How much of these tobacco products do you use daily?_____
Do you drink coffee or use other stimulants, such as caffeine? Yes_____ No_____ Which ones and how much do you consume daily? _____
Do you eat or drink milk products? Yes____ No_____ Which ones and how much do you take daily?_____
_____
Do you eat foods containing sugar such as candy, soft drinks, cakes, cookies, pies, doughnuts, pastries, ice cream, etc? How much of these do you consume on a daily basis? _____
_____
Do you drink alcoholic drinks? Yes ____ No____ How much alcohol do you consume on a daily basis? _____

Please list all food supplements such as vitamins, minerals, protein, herbs, or botanicals that you are taking. _____
_____
_____
_____
_____
_____
_____

How much water in ounces do you drink daily? _____
What kind of water do you drink? Tap ____ Distilled ____ Bottles ____ R.O._____ Other _____
What percentage of the food that you eat is taken in as raw food? _____

Do you presently exercise? Yes ___ No___ If yes, please describe the kind of exercises that you do and how often you do them. _____
_____
_____
_____

Please describe any stress or tension that you may be experiencing _____
_____
_____
_____

Do you enjoy life? _____

Please describe the amount of control that you presently have in your life. (are you in control or are circumstances in control of your life?) _____
_____
_____
_____

Please describe your typical day or week? _____
_____
_____
_____
_____

Please use this section to tell us anything about you or your health that we have not asked you that you think we should know about. _____
_____
_____
_____