Wasatch Chiropractic

Dr. Shawn Campbell

PATIENT INFORMATION

Today's Date: ________

Legal First Name: ____________ MI: ____ Last Name: ____________

Street Address: ____________________ Apt: ______

City: ____________ State: ________ Zip Code: ________

Gender: ☐ Male ☐ Female Marital Status: S M W D Spouse's Name: ____________

Date of Birth: __________ Email Address: ____________

Home Number: ____________ Work Number: ____________

Cell Number: ____________ Cell Carrier: ____________

Please select your preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Standard Mail

Employer: ____________ Occupation: ____________

In case of Emergency, who should we contact: ____________ Phone Number: ____________

Whom may we thank for referring you to our office? ____________

Recent Car Accident? ☐ Yes ☐ No **Recent Work Injury?** ☐ Yes ☐ No

MAIN COMPLAINTS: ____________

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HEALTH HISTORY Height: ________ Weight: ________ Blood Pressure: ________

Have you been diagnosed with Diabetes? ☐ Yes ☐ No If yes, include date & provider seen:

Type I ☐ or Type II ☐ ____________

Have you been treated for hypertension? ☐ Yes ☐ No

Do you smoke? ☐ Never ☐ Former Smoker ☐ Current/Every day smoker ☐ Current/Some Day Smoker

Do you have allergies? ☐ No known allergies ☐ Food ☐ Environmental ☐ Medication

Allergic to: 1. ____________ 2. ____________ 3. ____________

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Mild ☐ Moderate ☐ Severe ☐ Mild ☐ Moderate ☐ Severe

Reception(s): ____________

SUPPLEMENTS / MEDICATIONS *What vitamins, supplements and medications are you currently taking?*

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