Stewart Family Chiropractic

Welcome to our practice

I am truly please that you are seeking chiropractic care and that you are considering us for your family chiropractor. I look forward to taking care of you and your family.

PERSONAL INFORMATION

Date ________________

First Name _______________________________ Middle Initial ________ Last Name _________________________________

Preferred Name (what do you like to be called?) ____ Gender M / F

Address ____ City_________________________ State_____ Zip_______

Birth Date ____________________ Age_______ Occupation___________________ Employer ________________________

Marital Status_________ Spouse's Name__________________________ Number of Children__ _____________________

E-mail Address ____

Phone Numbers	Best # to call	
	Day	Early Evening
Land Line (____)_____-_____________	☐	☐
Work (____)_____-_____________	☐	☐
Cell (____)_____-_____________	☐	☐

Who may we thank for referring you to our office?

1473 Ebenezer Road ● Rock Hill, SC 29732 ● Phone 803-327-6100 ● Fax 803-327-6224

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Name ____ **File Number** _____________

PERSONAL HISTORY

*** Please use back of form for long responses.**

CHIROPRACTIC HISTORY

For which of these reasons did you seek chiropractic care? (Please check one)

☐ Better expression of life through correction of vertebral subluxation

☐ Other (please describe) ____

Have you had previous chiropractic care? Y/N Dr.'s name _______________ How long were you under care and how often were you

checked?_________________Date of last adjustment.__________Did he/she take spinal x-rays? _______ Date of last set of films _____________

MEDICAL/DENTAL/LIFE HISTORY

Give dates and details of any general traumas, accidents, falls, injuries, etc., that have happened over the course of your life (from birth to present, even if you think it had no effect on your spine)

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____

List all surgeries (not just spinal) and broken bones that have occurred during your life ____

____

List any serious illnesses that have occurred during your life ____

____

Are you currently under medical care? ______ Dr.'s Name ____ Date of last visit ________________

List current medical diagnosis and treatments ____

List medications you are currently taking (including regular use of over-the-counter drugs, such as Asprin) _____________________________________

____

List times you have been x-rayed, had a CAT scan, angiogram, PET scan, or MRI, and what for ____

____

Have you ever received radiation therapy or chemotherapy? (list) ____

List major stresses in your life ____

(Female patients) Do you have any reason to believe you may be pregnant? Yes / No

DOCTOR'S NOTES

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Your signature ________________________________ Today's date _______________