Elevation Health Patient Application

WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

Section 1: Patient Information **Appt. Date:** **Referred *By:***

Name (first, middle, last):____

Preferred Name: ______________________ Male Female Date of Birth: M / D / Y Age: _______

Address: ______________________________________ City: _______________ Postal Code: __________

Home Phone: (____) ____________ Cell Phone: (____) ______________ Work Phone: (____) __________________

Marital Status: Married Common-law Divorced Widow Engaged Single

Employer: _________________ Occupation: _________________ Email: ____________________________

Name of Spouse/Significant Other: ____________ Name & Ages of Children:__________________________

Emergency Contact: __________________ Relationship_________________ Phone # (____) _______________

Name of Family Physician: ______________________________

Section 2: Chiropractic History

Have you ever seen a Chiropractor before? Yes No When M / D / Y

For what reason were you seen?______________________ Were you helped? YES NO

Section 3: Your Health Summary

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

List any medications you are taking and for what reason: ______________________________________

____

____

Patient/Guardian's Signature: Date: M / D / Y

FAMILY HEALTH HISTORY

Patient Name ____ Date ____________________

Family history is required to determine any family patterns or conditions that can be passed on in families. This helps to assess any possible present or future health concerns. This also helps the Doctor be aware of spinal and neurological potential causes and areas of concerns.

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. The designation **D** should be used if family member is deceased. Leave blank those spaces that do not apply.

	Father Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____	Age____	**Sister**(s) Age____	Age____	**Children** Age____	Age____	Age____
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										