



ALTERNATIVE HEALING CHIROPRACTIC CENTER

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576 Donnelly Ave, Coos Bay, Or 97420

Telephone: 541-266-7543 Fax: 541-269-9408

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Age: _____ Birth Date: _____

Gender: Male Female Height: _____ Weight: _____ Social Security #: _____

Marital Status: Married Single Widowed Divorced Spouse's Name: _____

Home Phone: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: Same As Above _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

- Type of health coverage: Cash Medicare Accident Worker's Compensation
- Have you had previous chiropractic care? Yes No If yes, how long ago? _____
- I require a Clinical Summary for each of my visits. Yes No

Race (Please Check Only One):
<input type="checkbox"/> American Indian/Alaska Native
<input type="checkbox"/> African American/Black
<input type="checkbox"/> Native Hawaiian/Other Pacific Islander
<input type="checkbox"/> Asian
<input type="checkbox"/> White

Smoking Status:
<input type="checkbox"/> Daily Smoker
<input type="checkbox"/> Occasional Smoker
<input type="checkbox"/> Former Smoker
<input type="checkbox"/> Never Smoked (<100 Cigarettes in lifetime)

Ethnicity:
<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> Not Hispanic/Latino

- Are you currently taking any **Prescription Medications**? Yes No If yes, please list below.
If you have a list of your medications with you, we can make a copy.

_____ Initials I authorize Alternative Healing Center to access my prescribed medication history, and check for possible drug interactions.

Prescription Name	Mode of Delivery (Pill, Capsule, Injection, etc)	Dosage	Frequency (1x/day, 2x/day, as needed, etc)

- Do you have any **allergies** to *prescription medications*? Yes No If yes, please list below and indicate **what type of reaction** you have to the medication (Hives/rash, anaphylactic shock, etc.)

Signature of Patient/Personal Representative/Guardian

Date