SPINOS FAMILY CHIROPRACTIC
1000 N Center Street
Ebensburg, PA 15931
814-419-8445

Patient Information

Name: _____

Please answer the following questions:

Height_____ ft. _____inches Weight _____lbs.

Smoking Status

◯ Current every day smoker
◯ Current some day smoker
◯ Former smoker
◯ Never smoker

Do you have any medication allergies?

◯ No known medication allergies
◯ Yes
Please list: _____

Are you currently taking any medications? *If you have a list, we can make a copy.

◯ Not currently prescribed any medications
◯ Yes
Please list:

_____

_____

_____

_____

_____

_____

Personal/Family History

DISEASE/CONDITION (Please check all that apply and circle the appropriate answer)

Arthritis	□	Self	Mother	Father
Osteoarthritis	□	Self	Mother	Father
Rheumatoid Arthritis	□	Self	Mother	Father
Fibromyalgia	□	Self	Mother	Father
Asthma	□	Self	Mother	Father
Heart Disease	□	Self	Mother	Father
High Blood Pressure	□	Self	Mother	Father
Thyroid Disease	□	Self	Mother	Father
Diabetes	□	Self	Mother	Father
Kidney Disease	□	Self	Mother	Father

Autoimmune Type: _____ Self Mother Father

Cancer Type: _____ Self Mother Father

Other: _____ Self Mother Father

Please list any major surgeries below: **DATE**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

WOMEN ONLY:

To the best of my knowledge **I am/am NOT pregnant** (please circle)

I give my permission/don't give my permission to x-ray me for diagnostic interpretation (please circle)