KARE
CHIROPRACTIC
"Because We Care About Your Health"

Demographic Paperwork

Please complete this form to the best of your ability. If you need help our receptionist will gladly assist you!

Today's Date:_____

Legal Name : _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Sex: ☐ Female ☐ Male

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____ Height: _____ Weight: _____

*Email(*required*): _____

Email is used for secure patient portal communication, online scheduling, and electronic statements.

Employer: _____ Occupation: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Do you give us permission to contact this person in the event of an emergency? ☐ Yes ☐ No

How did you hear about our office? _____

Primary Care Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Allergies

☐ Penicillin ☐ Morphine ☐ Dye Allergies ☐ Codeine

☐ Aspirin ☐ Nitrate Allergy ☐ Seasonal (Pollen) ☐ Sulfa Drug

☐ Food Allergies ☐ Other: _____

Please describe allergic reaction you experienced and when it occurred: _____

_____

_____

Medical Conditions and Diseases

Please check all personal history that applies to you:

☐ Diabetes ☐ Osteoporosis ☐ High Blood Pressure ☐ High Cholesterol

☐ Heart Disease ☐ Cancer ☐ Kidney Disease ☐ Liver Disease

☐ Thyroid Disease	☐ Anemia	☐ Smoker	☐ Fibromyalgia
☐ Nausea/Vomiting	☐ Acid Reflux	☐ Diarrhea	☐ Constipation
☐ Ulcers	☐ IBS	☐ Diverticulitis	☐ Crohns/IBD
☐ PCOS	☐ Chronic Fatigue	☐ Currently Pregnant	☐ Birth Control

Other (Please List): _____

Family Medical History (Please List): _____

_____

_____

Current prescription medications, vitamins, and supplements(including nutritional/protein supplements) you are presently taking (Please list all including OTC, herbs, ect): _____

_____

_____

_____

I acknowledge and agree to the **Patient Health Information Consent Form**.*

I acknowledge and agree to the **Missed Appointment Policy** including the **$50** missed appointment fee.*

Policies are available on the clipboard for review.

Patient/Parent/Guardian Signature(X): _____ **Date:** _____

By signing below, I consent to receive treatment from Kare Chiropractic. I understand that this includes care provided by its owners, officers, directors, employees, independent contractors, agents, representatives, and affiliated professionals. I confirm that the health information I have provided is complete and accurate to the best of my knowledge, including a full disclosure of all medications I am currently taking and any known allergies. I hereby release Kare Chiropractic and all aforementioned parties from any liability arising from the treatment I receive

Patient Signature(X): _____ **Date:** _____