



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

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Morphine | <input type="checkbox"/> Dye Allergies | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitrate Allergy | <input type="checkbox"/> Seasonal (Pollen) | <input type="checkbox"/> Sulfa Drug |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Other: _____ | | |

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

Medical Conditions and Diseases

Please check all personal history that applies to you:

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Smoker | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> IBS | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Crohns/IBD |
| <input type="checkbox"/> PCOS | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> 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:** _____