



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 Assigned at Birth: ☐ Female ☐ Male

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

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____

*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: _____

May we forward our findings to your doctor? ☐ Yes ☐ No

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 medications, herbs, ect): _____

PHI/MISSED APPOINTMENT POLICY

I acknowledge and agree to the **Patient Health Information Consent Form**, and I confirm that all of my questions have been answered.*

I acknowledge and agree to the **Missed Appointment Policy**, including the **up to \$75** missed appointment fee.*

**Policies are available on the clipboard or upon request at any time for review.*

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

ACKNOWLEDGMENT

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 Name Print: _____

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