

Patient Health History



AMMONS
CHIROPRACTIC
CLINIC

Referred by _____

Today's Date Signature of Patient _____

SSN _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth Age _____ Gender (check one) Male Female Unspecified

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Employment Name _____ Work Number _____

Marital Status (check one) Single Married Other Spouse Name _____

Spouse Date of Birth _____ SS# _____ Phone # _____

Spouse Employment Name _____ Work Number _____

Race (check one)

White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino
 Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
 Samoan Guamanian or Chamorro Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

