Dr. Lisa Gordon

Your Gentle Family Chiropractor

Please fill in all of the following information.

Name_____Date_____

Full address_____

_____

Email_____ Home phone_____

Cell Phone_____ Work Phone_____

Birth Date_____ Age_____ Occupation_____

Employer_____

Marital Status (please circle) Single Married Partnered Divorced Widowed

Spouse or Partner's Name_____
His or Her Occupation_____

Children's Names and ages_____

Your Interests and Hobbies_____

Whom may I thank for referring you? _____

What are your current health concerns and what results are you hoping I can help you achieve?

1._____
2._____
3._____

What else have you done to resolve your health concerns, and with what results?

1._____
2._____
3._____

Have you had a similar condition in the past? Yes____ No_____

If so, please describe its history.

_____

_____

Is it getting worse? (Circle one) Yes No Constant Comes and goes

What makes it worse? _____

What makes it better? _____

How does the condition affect your life? In other words, what would you like to be able to do that you have trouble doing because of the condition with which you are hoping I can help?

_____

_____

Have you had chiropractic care before? Yes ___ No ____ With whom? _____

Is this a result of an automobile accident or a work related injury? Yes _____ No _____

If so, when did that injury occur and please describe it.

_____

_____

Please describe any pertinent family history.

_____

_____

What other doctors or health care providers do you use and for what reasons?

1._____
2._____
3._____

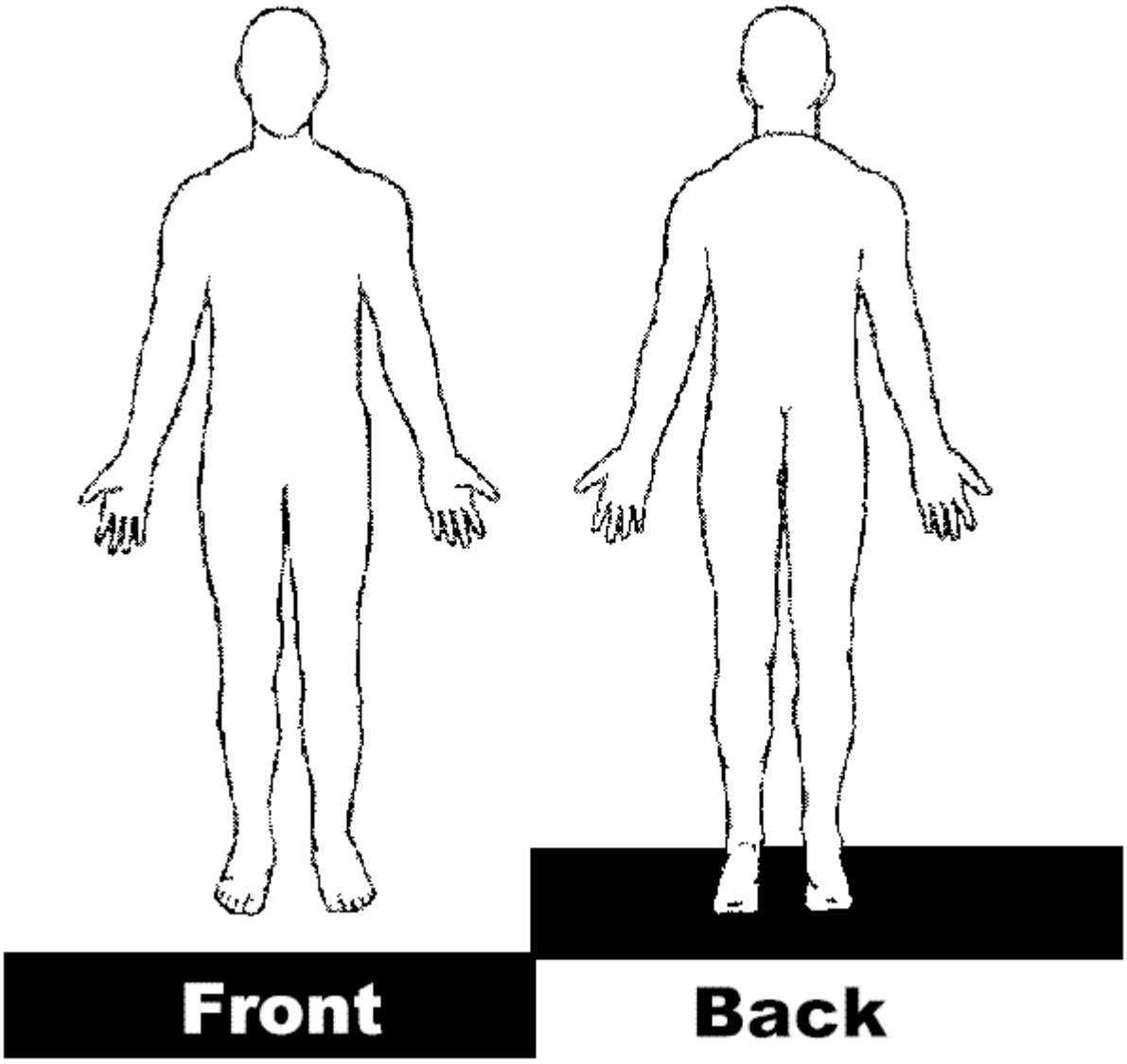
What surgeries have you had?

1._____
2._____
3._____

What medications and nutritional supplements are you currently taking?

1._____2._____
3._____4._____

Please mark the areas where you are experiencing pain, numbness, tingling or other discomfort.



Confidential: Please notify me if you are HIV positive, have tuberculosis, hepatitis or any other communicable disease.

Are you pregnant? (Circle one) Yes No Not sure

If so, when is your due date? _____

Please list any complications if any.

_____

If you have ever had cancer, any neurological, autoimmune or other chronic illness, or anything else that has not been included in this history form, please describe the condition, treatments you have had and pertinent dates. Feel free to use more pages of paper if necessary.

_____

_____

_____

Circle if you have ever experienced any of these conditions:

1)Dizziness 2)Neck Pain 3)Back Pain 4)Neuritis 5)Headaches or Migraines

6) Arthritis 7)Asthma 8)Allergies or Sensitivities 9)Digestive Difficulties

10) Anxiety 11)ADD 12)ADHD 13) Learning Difficulties 14)Trouble with Balance

15)Heart Illness 16)Diabetes 17)Sinus Problems 18)Insomnia 19) Foggy Thinking

Please provide details of any of the above that you circled using extra paper if necessary.

_____

_____

Office Policies:

It is my priority to give each of my patients the utmost attention and I make every effort to see each patient at his or her scheduled appointment time. I appreciate your consideration and will do my very best to honor your time as well.

Fees are due in full at the time of the visit. Cash, checks and credit cards are accepted. Missed appointments without 48 hours notice will incur a fee.

I agree to have Dr. Lisa Gordon treat my child _____

This document is true and accurate to the best of my knowledge on this date.

Date _____

Signed _____