



Dr. Crystal's Chiropractic Care
419 N. Cody Rd., Le Claire, IA 52753 (563) 271-0226

Patient Name: _____
First MI Last Nickname / Preferred Name

Date of Birth: ____/____/____ Gender: ☐ M ☐ F ☐ N Height: ____ft. ____in. Weight: ____lbs.

Address: _____
Street Apt. # City State Zip

Phone #: (____) ____-____ ☐ Cell ☐ Home Email: _____

May we contact you through text messages? ☐ Yes ☐ No Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Marital Status: ☐ Married ☐ Single ☐ Civil Union ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name: _____ Ages of Children: _____

Emergency Contact Name: _____ Phone #: (____) ____-____ Relationship: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

Current or most recent job: Employed by: _____ Occupation: _____

Physical aspects of your job (e.g. standing for hours, heavy lifting, desk work): _____

Non-work related exercise (e.g. walking, weight-lifting): _____

How much water do you drink per day? _____ Do you eat fresh fruits and green vegetables every day? ☐ Yes ☐ No

How long has it been since you've received chiropractic care? _____

Previous Chiropractor's Name: _____ Phone #: (____) ____-____

How did you hear about us? ☐ Signs ☐ Phone book ☐ Ad ☐ Internet Referral: _____ Other: _____

Guardian Info (person responsible for patient): ☐ Patient ☐ Parent Other relation: _____

If patient is **not** the guardian, please enter the responsible party's information:

Name: _____ Birth date: ____/____/____ Phone #: (____) ____-____

Address: _____
Street Apt. # City State Zip

Insurance Policyholder's relationship to the patient: ☐ Self ☐ Spouse ☐ Parent Other: _____

If patient is **not** the policyholder, please enter the policyholder's information: ☐ Same as Guardian

Name: _____ Birth date: ____/____/____ Phone #: (____) ____-____

Address: _____
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New Patient

What **primary concern** brings you into the office today? _____

Please **describe when and how** this ailment began: _____

Please list all of your past **Surgeries**:

Year: _____ Procedure: _____ Complications: _____

Year: _____ Procedure: _____ Complications: _____

Year: _____ Procedure: _____ Complications: _____

Year: _____ Procedure: _____ Complications: _____

Please list your past **Major Illnesses/Diagnoses/Traumas**:

Please list any **Allergies/Sensitivities**:

Please list any **Medications or Supplements** you are currently taking:

_____	_____
_____	_____
_____	_____

Is there anything else I should know about you?

All information submitted is true to the best of my knowledge. I have read and I agree to all of the policies and procedures set forth within the Patient Health Information; Authorizations, Assignment of Benefits and Consent to Treat; and Notice of Privacy Practices (Rev 7/1/2013).

Patient/Guardian Signature

Date