Today's Date_____
Referred By_____

Dr. Kenyon L. Erickson, D.C., F.A.S.A.

PATIENT INFORMATION		GUARDIAN INFORMATION		
Name		Name		
Address		Address		
City/State/Zip		City/State/Zip		
Phone	Cell Ph:	Phone		
Birth Date	Male or Female	Birth Date	Age	Male or Female
Social Security Number		Social Security Number		
Student	Full-Time or Part-Time	Student		Full-Time or Part-Time
Employer	Phone	Employer		Phone
Occupation	Full-Time or Part-Time	Occupation		Full-Time or Part-Time
Retired	Date	Retired		Date
Marital Status S M W D		Marital Status S M W D		
Name of Spouse	Birth Date	Name of Spouse		

**Where do you want your itemized statements mailed?
Circle: **Self** or **Other** (if other please specify name and address):

Allergies
Current Medications/Vitamins/Supplements

Date of last menstrual period	Could you be pregnant?

Have you lost or gained weight in the past year?	How many pounds? Why?
How do you exercise?	

Primary complaint (Be specific)			
How did your problem begin?			
If this was an injury, list the date/place it occurred.			
What positions/activities aggravate your condition?			
What positions/activities relieve your condition?			
Have you received treatment for this?		Explain	
Is this related to: Employment	Auto accident	Other accident	None of these
Date of first symptom and/or injury		Date of same or similar situation	
Dates you were unable to work due to this situation:			

Have you ever had chiropractic care?	Name of Chiropractor
Why?	When? What were the results?
Name of Primary Care Physician	

Hobbies:
List amount of alcohol, tobacco, caffeine, drugs:

Have you ever been in any auto accidents or falls?	Explain
Have you ever broken or dislocated any bones?	Explain
List past operations and the dates.	

Please circle the symptoms that you have had Now and/or in the Past

Headache:	Now	Past
Stiff Neck:	Now	Past
Chest Pain:	Now	Past
Fainting:	Now	Past
Loss of Balance:	Now	Past
Tension/Anxiety:	Now	Past
Shortness of Breath:	Now	Past
Diarrhea:	Now	Past
Diabetes:	Now	Past
Numbness:	Now	Past
Cramps:	Now	Past
Fever:	Now	Past
Cancer:	Now	Past
Loss of Smell/Taste:	Now	Past
Eye Problems:	Now	Past
Cold Hands/Feet:	Now	Past
Upset Stomach:	Now	Past
Gallbladder Problems:	Now	Past

Neck Pain:	Now	Past
Back Pain:	Now	Past
Shoulder/Arm Pain:	Now	Past
Dizziness:	Now	Past
Memory Loss:	Now	Past
Sleeping Problems:	Now	Past
Cold Sweats:	Now	Past
Constipation:	Now	Past
Arthritis:	Now	Past
Weakness:	Now	Past
Swelling:	Now	Past
Frequent Illnesses	Now	Past
High Blood Pressure:	Now	Past
Buzzing/Ringing in ears:	Now	Past
Sinus Problems:	Now	Past
Muscle Spasms:	Now	Past
Urinary Problems:	Now	Past
Mental Illness:	Now	Past

List other past and present health information: _____

Give most recent date/results of the following:

Blood Tests	Urine Test
MRI	CT Scan
Ultrasound	X-ray
Radiation Treatment	Chemotherapy
Other	

List medical history for parents and siblings:

All information is correct to the best of my knowledge. I understand/agree that insurance policies are an agreement between the insurance carrier and myself. I am personally responsible for payment. I also understand that if I suspend or terminate my care, all fees for professional services rendered me will be immediately due and payable.

Patient Signature: _____ **Guardian Signature:** _____