Wootton Chiropractic
Wellness Center

Patient Name ____ Todays Date: ____ /____ /____

Date of Birth: ____ /____ /______ Gender: M / F

Current Address

Street ____

City____ State _______ Zip _________________

Phone (____) _____-___________

Email Address____

Do you use tobacco? __ YES __ NO

If yes how frequently: ______________________________ Approximate year started: _________

List any medications you are currently taking:

_________________________ ______________________ ___________________

_________________________ ______________________ ___________________

List any allergies:

_________________________ ______________________ ___________________

Do you have health insurance? ____ YES ____ NO

(If you have health insurance please make sure we have a current copy of your most updated card.)

Optional Questions

Race

____ Decline to Specify

____ American Indian or Alaskan Native

____ Asian

____ Black or African American

____ Native Hawaiian or Other Pacific Islander

____ White

____ Other Race

Preferred Language _____________________________________ ____ Decline to Specify

By signing this form you are confirming that all information above is correct.

Patient or Guardians Signature ____