Cari Cater, Dipl.LAc

Patient Health History

Name: ____ Date: _____/_____/______

Date of Birth: _____/_____/______ Age: _______ Gender: Male / Female

Address: ____ Home #: _____________________

City __________________State __________Zip ___________

Email: ____

Emergency Contact___________________________________ Phone________________________

1. Are you currently under a physician's care? Y N Name of physician: _______________________________

   Currently being treated for? ____

2. Have you ever had chiropractic or acupuncture care before? Currently?

____

3. Have you ever had any major surgeries? Dates?

____

4. Please identify the health concerns that have brought you to the office today in order of importance.

For Office Use Only:		Condition	How Long	Past Treatment
______________	a.	____________________	____________________	______________________________
______________	b.	____________________	____________________	______________________________
______________	c.	____________________	____________________	______________________________
______________	d.	____________________	____________________	______________________________

How does this condition affect you? ____

5. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to. (Please include your reaction.)

____

____

6. Please list any medications (prescribed or over-the-counter), vitamins, or supplements you are currently taking.

____

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7. How did you hear about us?

____

Disclaimer: I agree to receive treatment from Cari Cater, Dipl. LAc. I acknowledge that no claims, promises, or guarantees are being made as to the results and effectiveness of any treatment and therefore accept full responsibility for the outcome of said treatment. Understand that payment is expected at the time of service and that Cari Cater, Dipl. LAc does not accept insurance, but that if asked she can provide an invoice for you to turn into your insurance company.

Patient's Signature: ____ **Date:** _____________________