TRULL CHIROPRACTIC, P.A. 1739 Dale Earnhardt Blvd, Kannapolis, NC 28083 (704) 938-1141

Date: _____

First name: _____ Middle name: _____

Maiden name: _____ Last name: _____

Suffix: _____ Name you wish to go by: _____

Address: _____

City: _____ State: _____ Zip code: _____

Preferred contact: ❑ Cell phone ❑ Home phone ❑ Work phone ❑ Other: _____

Cell phone: _____ Please send text message reminders for my appointments: ❑ Yes ❑ No

Home phone: _____ May we call you at work? ❑ Yes (#_____) ❑ No

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Preferred email address: _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Birthdate: _____/_____/_____

Sex: ❑ Male ❑ Female

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse/significant other's full name: _____ Is your spouse a patient? Yes / No

Cell phone: _____ Home phone: _____ Birth date: _____

How did you hear about us? _____ Who referred you? _____

Employment: ❑ Employed ❑ Full-time student ❑ Part-time student ❑ Unemployed ❑ Retired

Employer/school: _____ Occupation: _____

Emergency contact's full name: _____

Relationship: _____ Phone number: _____

Children's names *and* ages: _____

_____

Are you currently pregnant? ❑ Yes (due date: _____/_____/_____) ❑ No

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Briefly list your main health problems, including those related to your medications:

_____

_____

PLEASE FILL OUT BOTH SIDES COMPLETELY.

List ALL current medications:	**Why was this prescribed?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

** Please note: Failure to list medications will result in our office reporting "NO MEDICATIONS for this patient."

Has any doctor diagnosed you with high blood pressure/hypertension presently? ❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No

If yes, what kind? ❑ Type I ❑ Type II

Have you ever had a surgery? ❑ Yes ❑ No

If yes, please list: _____

Have you ever had a fracture/broken bone? ❑ Yes ❑ No

If yes, please list: _____

Have you ever been in an accident? ❑ Yes ❑ No

If yes, please list: _____

Signature of Patient: _____

MEDICARE PATIENTS:

Medicare #: _____ Supplemental insurance: _____

I authorize the release of any medical or other information necessary to process my insurance claim(s). I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed: _____ Relationship, if not self: _____

TO BE PERFORMED BY CLINIC STAFF: **HT** _____inches **WT** _____pounds **BP** _____ / _____ R / L

PLEASE FILL OUT BOTH SIDES COMPLETELY.