



Valley Chiropractic: A
Creating Wellness Center
3910 East Pages Lane
Louisville, KY 40272
(502) 937-4000 fax (502) 937-4456
valleychiropractic.com

Personal Information

Name _____ Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Work _____
Email Address _____
(Preferred method of contact: Phone ___ Text ___ Email ___ Mail ___)

Social Security Number _____ Male ___ Female ___
Single ___ Married ___ Divorced ___ Widowed ___ #Children ___ Ages _____
Race: White ___ African American ___ Hispanic ___ Asian ___ Other ___
Preferred Language: English ___ Spanish ___ French ___ German ___ Other _____

Occupation _____ Employer _____

Spouse's Name _____ Employer _____
Spouse's SSN _____ Spouse Date of Birth _____

Whom may we thank for referring you to our office? _____

General Health Information: Required for Health Records

Have you been diagnosed with having: Diabetes: ___ Yes ___ No
Asthma: ___ Yes ___ No
Cancer: ___ Yes ___ No

Smoking Status: Never Smoked___ Smoke Everyday___ Smoke some days___ Former Smoker___

Please list all surgeries:

1. Type _____ Date _____ Doctor _____
2. Type _____ Date _____ Doctor _____
3. Type _____ Date _____ Doctor _____

List any medications you are taking: Check here if taking no Medication ___

Name of Drug	# refills issued	Quantity of pills	Strength: i.e. 10 mg	Dose Form: i.e. capsule	MD instructions, i.e. 1 per day

Are you allergic to any medications? Please list each drug and symptoms.

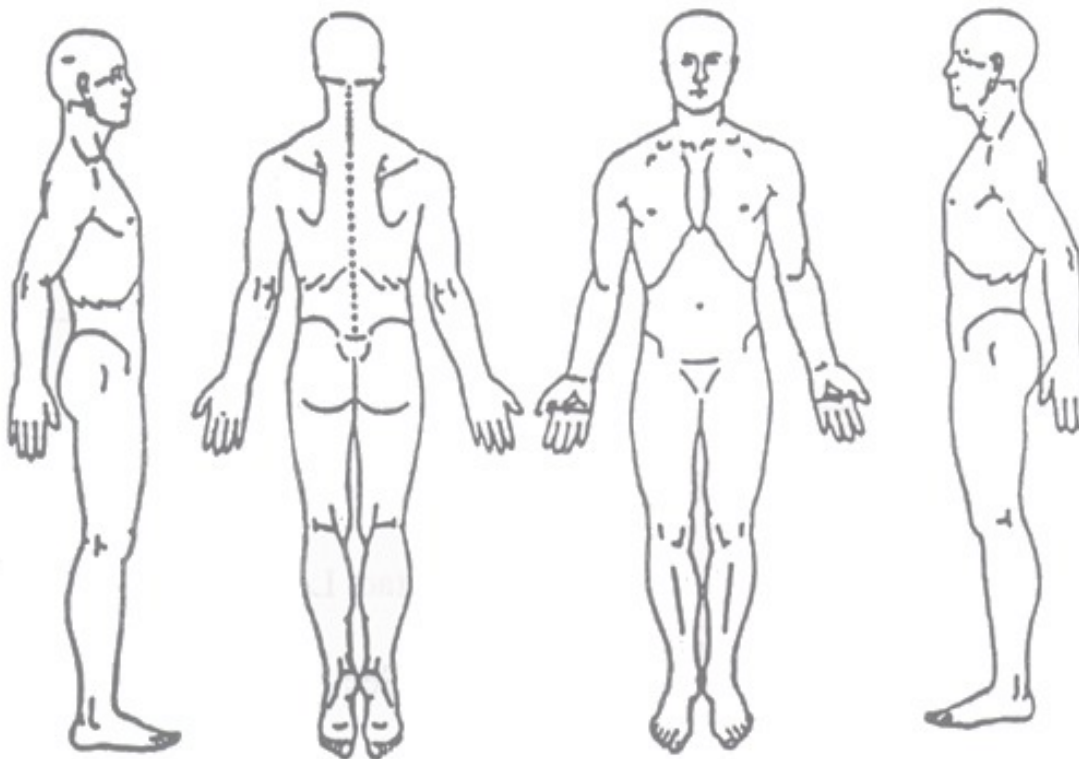
Click here if you do not have any Medical Allergies: _____

Name of Drug: i.e. penicillin	Symptoms: i.e. Headache

Pain Indicator:

Please use the following symbols to indicate on the drawings below the type and location of your pain:

Type of Pain	Symbol
Sharp	X
Shooting	>
Burning	B
Aching	A
Spasming	S
Tingling	T
Numbness	N



Patient Signature _____ Date _____