BIONIIC Chiropractic
108 E. Arctic Ave.
Palmer, AK 99645

Joseph T. Hawkins, D.C.
PH: (907)745-4357
Fax: (907)745-4606

Today's Date _____

PATIENT INTRODUCTION FORM

Legal Name _____Nickname_____
FIRST NAME LAST NAME M.I.

Mailing Address_____
Street Address/ P. O. Box City State Zip

Residential Address_____
Street Address City State Zip

Home Phone (____)_____ Cell (___)_____ Work (____)_____
Date of Birth ____/____/____ Age ____ Gender ____ ____ SSN: _____ -_____ -_____
Male Female

Marital Status: M____S____W____ D____Separated____ Spouse's Name:_____

Emergency Contact_____ Telephone (____) _____

Address_____
CITY STATE ZIP

MY CONDITION IS RELATED TO A:

____ Work Injury* ____ Car Collision Injury* ____ Sports Injury
____ Non Injury Symptoms ____ Check-up Only ____ School Physical
____ Slip-and-Fall Injury ____ Home Injury
Other: _____

If this is a work related or car collision injury, ask the receptionist for the other paperwork.

How did you hear about us: ____sign, ____newspaper, ____phone book, ____other_____
friend/relative _____
(Please include their name so we can properly thank them.)

Employment

Employer _____
Job Title _____

What is the best way to contact you?

(Please only check the box as consent to leave a message**)**

Cell Phone Voice Mail ____ Text Message ____
Home Phone Voice Mail ____
Work Phone Voice Mail ____ Text Message____
Email _____

Would you prefer an appointment reminder? ____Yes ____No
Email____ VM____ Text____ # _____
Cell Phone Carrier_____

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Personal Health History

Main complaint: _____

When did this condition begin? _____

Currently under a Doctor's care? ____Yes ____No Reason_____

Currently taking any medications? ____Yes ____No What?_____

Do you use tobacco? (smoke or chew) ____Yes ____No Do you smoke marijuana? ____Yes ____No

Have you ever been treated by a chiropractor before? ____Yes ____No Who?_____

Have you been treated for this or a similar condition
in the past? ____Yes ____No When?_____

By whom? ____DC ____MD _____

Length of treatment?_____

Results of treatment? ____no relief ____moderate relief ____full recovery

Any major illness in the past? (please list)_____

Any surgeries or operations? (please list)_____

Women only: Is there any chance you may be pregnant? ____Yes ____No

If pregnant in the past, were pregnancies uncomplicated? ____Yes ____No

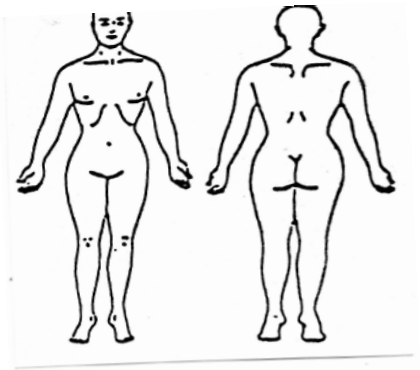
Conditions or Illnesses

Please indicate if you Now Have or Have Had in the Past any of the following conditions or illnesses.

____No current or previous conditions/illnesses

Now	Past		Now	Past	
____	____	Dizziness	____	____	Heart Trouble
____	____	Backaches	____	____	High Blood Pressure
____	____	Headaches	____	____	Low Blood Pressure
____	____	Diabetes	____	____	Nervousness
____	____	Arthritis	____	____	Sinus Trouble
____	____	Neuritis	____	____	Anemia
____	____	Tuberculosis	____	____	Rheumatic Fever
____	____	Asthma	____	____	Digestive Disorders
____	____	Allergies	____	____	Dislocated Joints
____	____	Cancer	____	____	Bone Fracture
____	____	Stroke			

Mark the areas of pain or injury on the illustrations below and give a word description of the symptoms you are experiencing in those areas.



_____

_____

_____

I understand that at times BIONIC Chiropractic may need to correspond with me via mail or telephone. I consent to such communication. I certify that the above information is true and correct.

Signed by responsible party: _____Date: _____

(Patient or Parent/ Guardian)