Santa Clara Chiropractic Center

2620 River Rd STE B

Eugene, OR 97404

(541) 688 - 3223

Confidential Patient History

Name:_____ Preferred Name:_____ Date:_____

Male☐ Female ☐ Non-Binary☐ Height: _____ Weight: _____

Address:_____

City: _____ State: _____ Zip: _____ Cell Phone Number:_____

Age:_____ DOB:_____ Email:_____

Occupation:_____ Employer:_____

Emergency Contact (Name and Phone number): _____

Referred by: _____

Insurance Company: _____ Member ID: _____

Group Number: _____ Inured Date of Birth: _____

Name of Insured: _____ Relationship to Patient: _____

Family doctor/ Primary Care Physician (PCP): _____

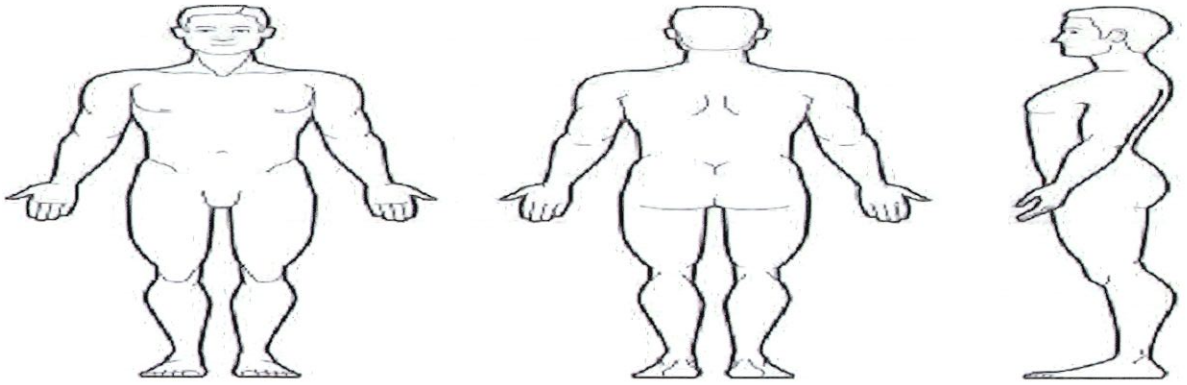
Name of PCP's office:_____

We normally keep your family doctor/ or referring physician informed regarding your care at this office.

Is that okay? ☐ Yes ☐No

Chief complaint:_____

Circle on the picture where you are experiencing your symptoms



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Medical History

☐ Anemia	☐ Depression	☐ Asthma	☐ Other
☐ Arthritis	☐ Dizziness/ fainting	☐ COPD	
☐ Cancer	☐ Fractures	☐ Seizures	
☐ Pacemaker	☐ Headache	☐ Thyroid Problems	
☐ Currently Pregnant	☐ Hepatitis/ HIV	☐ Diabetes	
☐ Low blood Pressure	☐ Kidney Problems	☐ Stroke	
☐ High Blood pressure	☐ Respiratory Problems	☐ Heart Disease	

If you checked any above, please explain:

_____

_____

Have you **ever** broken any bones? ☐ Yes ☐ No

Explain:_____

Have you been hospitalized or had a surgery for **any** reason? ☐ Yes ☐ No

Explain:_____

Have you **ever** been in an accident? ☐ Yes ☐ No

Injury Sustained:_____

Have you ever been to a chiropractor before? ☐ Yes ☐ No

Smoking Status: ☐ Every-day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Current Medication	Reason for Taking Medication

Patient's/ Guardian Signature:_____ Date:_____