# *WESTLAND CHIROPRACTIC LLC*

***Dr. Christopher T. Westland D.C.***

## *PATIENT DATA*

**DATE_____**

**NAME_____HOME PHONE_____CELL #_____**

**E-MAIL ADDRESS_____**

**ADDRESS_____CITY_____STATE_____ZIP_____**

**SEX: MALE / FEMALE AGE_____BIRTHDAY_____ HEIGHT _____WEIGHT _____**

**EMPLOYED BY_____POSITION/TITLE_____**

**WORK ADDRESS_____CITY_____STATE_____ZIP_____**

**WORK PHONE EXT./DEPT. PART-TIME / FULL-TIME**

**MAY WE CONTACT YOU AT WORK: YES / NO INS. THROUGH EMPLOYER: YES / NO**

**MARITAL STATUS_____NAMEOF SPOUSE_____**

**EMPLOYED BY_____POSITION/TITLE_____**

**STREET ADDRESS_____CITY_____**

**STATE_____ZIP_____WORK PHONE_____EXT./DEPT._____ PART-TIME/FULL TIME**

**MAY WE CONTACT YOU AT WORK: YES / NO INSURANCE THROUGH EMPLOYER: YES / NO**

**ARE YOU A PART TIME FLORIDA RESIDENT:_ YES / NO IF SO ,OTHER ADDRESS_____**

**CITY_____STATE_____ZIP_____ MONTHS LOCAL_____**

**(IN CASE OF AN EMERGENCY)**
**CONTACT_____RELATIONSHIP_____PHONE_____**

**WHO MAY WE THANK FOR YOUR REFERRAL_____**

## *HEALTH HISTORY*

**MAJOR SURGERIES/OPERATIONS: Appendectomy / Back Surgery / Gall Bladder / Hernia / Tonsillectomy / Other_____**

**LIST MAJOR ACCIDENTS OR FALLS UNRELATED TO PRESENT COMPLAINT:_____**

**LIST ANY BROKEN BONES:_____DATE OF LAST PHYSICAL EXAM:_____**

**DO YOU SUFFER FROM ANY CONDITION OTHER THAN THAT WHICH YOU ARE CONSULTING THIS OFFICE FOR:_____**

**HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST: YES / NO IF SO, HOW LONG AGO:_____**

**WHAT WAS THE PROBLEM:_____NAME OF CHIROPRACTOR_____**
**DID YOU RECEIVE RELIEF FROM THIS TREATMENT: YES / NO / TEMPORARILY**