

# Confidential Patient Information

## Hands of Life Hawaii, Inc.

Aloha! Welcome to our office! Please print and complete all questions. Thank you!

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Marital Status: M W D S No. of Children and ages: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Reason for seeking chiropractic care:

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Are you under the care of any other doctor? Yes No

If Yes, the conditions being treated for: \_\_\_\_\_

List any current medications:

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List any vitamins or herbs:

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Past surgeries & dates:

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Past accidents & dates:

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List any allergies:

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Mahalo for being complete and thorough!

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_