CHIROPRACTIC
HEALTH CLINIC OF HUNTSVILLE

DR. HUNTER P. LEE
806 Governors Drive SW, Suite 102
Huntsville, AL 35801
(256)801-7731

PATIENT INFORMATION

Patient Name: (First)	(Middle)	(Last)	Home Address: (Street)
Sex: Male Female Other	Date of Birth: (MM/DD/YYYY)		(Apartment/Unit #)
SSN:			(City/State/Zip)
Phone:	Phone: (Alternate)		Would you like to receive appointment reminders? No Yes If yes, how would you like to receive them? Text Email
E-Mail:			
Occupation:			Preferred Contact Method: (Circle Preferred) Mobile Home Work Email
Employer's Name:			Were you referred to us? If so, by whom? No Yes
Marital Status: Single Married Other			Please list any immediate family members that are patients of Chiropractic Health Clinic:
Spouse/Partner Name:			

EMERGENCY CONTACT

Name: (First)	(Last)
Relationship to Patient:	
Mobile Phone:	Home Phone:
Home Address: (Street Address)	(City/State/Zip)

Have you ever received chiropractic care before? No Yes	If yes, by whom?	Date of Last Visit:

Name of Family Physician:	Location of Family Physician: (City/State)

CHIEF COMPLAINT: In the space provided please give a description of your main complaint today and/or any symptoms you are currently experiencing including when you started to experience these symptoms.

Date of Onset:	Details:
Have these problems been getting better, worse, or staying the same? (Circle One) Better Worse Same	
Are there any activities, incidents, or events that may cause these complaints? (Circle One) Yes No	
If yes, please explain:	
Please list any other doctors you have consulted for this condition:	
Have you at any time in the past ever suffered a work injury? (If yes, please enter date of injury.) No Yes Date:	Have you been involved in auto accident in past 12 months? (If so, please enter date of accident.) No Yes Date:

Please list **all** medications (over the counter and/or prescribed) you are currently taking?

Please list **all** surgeries you have had with dates.

Medical History: Please check all medical conditions that you have had in the past or currently have:

	Asthma		Chest Pain		Diabetes		Loss of Balance		Stroke
	Arthritis		Concussion		Headache		Pacemaker	Other:	
	Cancer		Constipation		High Blood Pressure		Sleep Problems		

Family History: Please circle conditions that apply for immediate family members.

Cancer	Diabetes	High Blood Pressure	Heart Problems/Stroke	Rheumatoid Arthritis

Social History: Please circle all that apply.

Smoking History: past current occasionally rarely never	**Other Tobacco Use:** past current occasionally rarely never
Alcohol: past regularly occasionally rarely never	**Drug Use:** past regularly occasionally rarely never
How often do you exercise? regularly occasionally rarely never	**Are you currently pregnant?** Yes No