SALYER CHIROPRACTIC CLINIC

Dr. M. Ryan Salyer Dr. Lisa A. Salyer

Patient Information

Date: _____

Patient Name: _____ Birth Date: _____ Age: _____ Sex: M____ F_____

Home # _____ Cell # _____ Receive Texts? (please circle) **Yes** or **No**

Email Address: _____

Marital Status (please circle) Single Married Widowed Separated Divorced

Address: _____ City_____ State _____ Zip Code _____

Employer _____ Occupation _____ Work # _____

Spouse's Name _____ Spouse's Birth Date _____

Ethnicity (please circle) African American Asian Caucasian Hispanic/Latino Native American Other_____

Preferred Language (please circle) English Spanish Other _____

Prescribed Medications (please list below) *check this box if you are not taking prescribed medications* ☐

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Medical Allergies (please list below) *check this box if you have no medical allergies* ☐

Name of Drug	Symptoms	Severity

Smoking Status (please circle) Smokes Everyday Smoke Some Days Former Smoker Never Smoked

If you smoke, how many cigarettes do you smoke per day? _____

Whom may we thank for referring you? _____

Emergency Contact

Name _____ Relation _____ Phone # _____

I give permission to release medical information to this person, if requested. **Yes** ____ **No** ____

Name _____ Relation _____ Phone # _____

I give permission to release medical information to this person, if requested. **Yes** ____ **No** ____

Patient Signature: _____