



## JACKSONVILLE CHIROPRACTIC CENTER

14307 Jarrettsville Pike  
P.O. Box 38

Phoenix, MD 21131

Dr. Daniel T. Wise

(410)-592-7300  
Fax# (410) 666-0348

### New Client Information

Please print clearly

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

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

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

Shipping Address: \_\_\_\_\_

Home Phone : (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone : (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Easiest place to reach you: \_\_\_\_\_ May we leave a message? Y/N

#### Referred by:

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Current Complaints (reason you are here): \_\_\_\_\_

Current medications/drugs being taken with dosages: \_\_\_\_\_

Are you currently under the care of a physician or other health care professionals? If yes, please give name: \_\_\_\_\_

Are you currently taking vitamins, herbs or nutritional supplements? If yes, please list: \_\_\_\_\_

Personal Habits: Do you use the following and if so, how much?

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alco-  
hol \_\_\_\_\_ Soda \_\_\_\_\_ Sugar \_\_\_\_\_ Non prescription  
drugs \_\_\_\_\_

**HEALTH HISTORY:**

List any major illnesses, injuries, surgeries (with approx. dates):

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Any major scars or body piercings (please list):

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# of pregnancies: Are you currently pregnant: Y/N

Marital status (please circle): Single, Married, Divorced, Widowed

Name of Spouse or Partner:

Describe health of Spouse or Partner:

# of Children: Any concerns or health issues (if so, please list):

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Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Stroke / Other:

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Any household pets or other animals you or family members are in close contact with:

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How can we help you?

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**SIGNED:** **DATE:**