Victoria Chiropractic Clinic

L. Ray Franka JR, DC

Basic Patient Information

Name____ Date___________________________

DOB____/_____/_____ Age__________ Male ☐ F emale ☐• Social Security #_____________________________

Address________________________________ City___________________________ State________________ Zip____________

Primary phone_____________________ Other Phone _______________________ Email ______________________________

Occupation________________________ Marital Status_______________________ Spouse's Name________________________

Please check all that apply:

- ☐ Recent Infection
- ☐ Recent Fever
- ☐ HIV/AIDS
- ☐ Corticosteroid use – inhaler/injections
- ☐ Birth control
- ☐ High Blood Pressure
- ☐ Stroke (date)_________
- ☐ Dizziness/Fainting
- ☐ Numbness
- ☐ Urinary Retension
- ☐ Aortic Anuerysm
- ☐ Cancer/Tumor (type)_______________
- ☐ Osteoporosis
- ☐ Recent Trauma
- ☐ Fibromyalgia

- ☐ Prostate Problems
- ☐ Frequent Urination
- ☐ Pregnancy, # of births _________
- ☐ Abnormal Weight , ___Gain or ___ Loss
- ☐ Epilepsy/Seizures
- ☐ Visual Disturbances
- ☐ History of Low/Mid-Back pain
- ☐ History of Neck Pain
- ☐ Arthritis
- ☐ Recent Motor Vehicle Accident
- ☐ Others ___________________

- ☐ Recent X-Rays or MRI
  - Date taken: _____________
  - Where:________________

Who is your family doctor? __________________ Have you ever had chiropractic care? ☐Yes ☐ No Date of last care________

List medications you take/reason : ____

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List Surgical operations and dates : ____

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How did you hear about us? Personal Referral Yelp Facebook Website Other __________________

In Case of Emergency, please list the name of a friend or relative:

Name____ Phone: _________________________

Address: ____

Please turn over! We need to know more about you!