**Re-activation of Care**

According to our records, the date of your last visit was on: .

Please let us know if any of your contact information has changed:

FIRST NAME M.I. LAST NAME

STREET ADDRESS

CITY STATE ZIP

HOME PHONE MOBILE PHONE

WORK PHONE EXT.

EMAIL ADDRESS

OCCUPATION EMPLOYER

**I prefer to be contacted at:** Home Ph: Mobile Ph: Work Ph:

**Reason for todays visit:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Since your last visit, have you had any:**

Injuries: No Yes (please describe)— \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sickness: No Yes (please describe)— \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Conditions: No Yes (please describe)— \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries: No Yes (please describe)—

Chiropractic care: No Yes—Name of provider:

Medical care: No Yes—For what condition:

Physical therapy: No Yes—For what condition:

For women only—To your knowledge are you pregnant? No Yes

PATIENT SIGNATURE DATE