Dickason Chiropractic PC
140 S. Wilcox St. Unit D Castle Rock Co. 80104-1911
(303) 688-2300
Date: _____/_____/_____

Name: _____ **Patient ID Number:** _____ **Date of Birth** _____/_____/_____

Please fill out this section completely

What is your preferred Language?

☐ English ☐ Spanish ☐ Arabic ☐ Chinese
☐ French ☐ German ☐ Italian ☐ Japanese
☐ Korean ☐ Polish ☐ Portuguese ☐ Russian
☐ Tagalog ☐ Vietnamese ☐ Declined ☐ _____

Gender

☐ Male
☐ Female

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Race

☐ Black, African American Asian ☐ Asian ☐ White
☐ American Indian, Alaska Native ☐ Other ☐ Declined
☐ Native Hawaiian, Pacific Islander

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker
☐ Never Smoked ☐ Smoker, current status uknown ☐ Unknown, if ever

Medications ☐ I currently do not take any medications

_____ Dosage: _____ _____ Dosage: _____
_____ Dosage: _____ _____ Dosage: _____
_____ Dosage: _____ _____ Dosage: _____
_____ Dosage: _____ _____ Dosage: _____
_____ Dosage: _____ _____ Dosage: _____

Medication Allergies: ☐ No known medication allergies_____

_____

Patient Signature:_____ Date:_____

This section to be completed by the doctor

Height _____ in Weight _____ lbs Blood Pressure _____/_____ mmHg Right Arm / Left Arm

Pulse _____ bpm Respirations _____ rpm Temperature _____

Dr. Signature: _____ Date: _____