POEHLMAN CHIROPRACTIC AND NUTRITION CENTER

Name____ Date_____________

WE ARE NOW REQUIRED TO MAINTAIN THE FOLLOWING INFORMATION ABOUT OUR PATIENTS:

List of Medications

Name Dosage

Family History (circle as appropriate)

Family Member:	Disease:	Heart	Cancer(Type)	Diabetes(Type)	Other
Mother					
Father					
Sister					
Brother					
Son					
Daughter					

My smoking history:

Do you smoke now? Yes No How much? How many years?

What do you smoke? Cigarette Cigar Pipe E-Cig Other

Did you ever smoke? How much? How many years?

When did you quit?