HOYER CHIROPRACTIC
PATIENT INFORMATION SHEET

Patient Name: _____

Address: _____

_____

Phone: _____

Blood Pressure:_____
(Dr. Hoyer will do)

Height: _____

Weight: _____

Medications currently taking & dosages:

_____

_____

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

*Smoking Status: **(please circle correct answer)***

Never smoked: Never
Currently smoking: Yes or No
Former smoker: Yes or No

OFFICE USE ONLY: DX codes: _____,_____,_____,_____,_____,_____