

# Forbes Family Chiropractic, PC

115 S. Filbert St., Mechanicsburg, PA 17055

## Asyra Case History/Patient Information

Date: \_\_\_\_\_ Patient ID# \_\_\_\_\_ Doctor: Kevin M. Forbes, D.C.  
Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: M S W D  
Emergency Contact Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Health History

Please list any diagnosed or known conditions you have or had in the past: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any know allergies (including but not limited to: drug, food, environmental, allergens, fabrics or materials, herbal, etc.) that you may have: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all medications, vitamins, supplements, remedies and their dosages/frequency taken (daily, twice a day, weekly, etc) that you are **currently** on. Be as specific as possible with names of medications/supplements and please write as clearly as possible:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your chief complaints at present time (list the top 5 ) and approximately how long have you had them?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

I understand that the Asyra Machine testing for nutritional deficiencies, allergies, and other health problems will not be covered by my insurance. As such, I understand I will be responsible for the fees associated with the testing procedure as well as for any vitamins, supplements, or remedies prescribed at the time of service.

I also agree that the above information is complete and accurate to the best of my knowledge.

**I hereby give my consent to be consulted/counseled by Forbes Family Chiropractic, PC. I agree that their counsel does not substitute any medical treatment that I may be in need of. I release them from all liability and understand that if I am currently taking prescription medications, I will not under any circumstances discontinue them unless otherwise directed by my Physician. This testing will not be rendered as a medical device.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_