Leingang
CHIROPRACTIC & WELLNESS

Name: _____

Height: _____ Weight: _____

Race:

- ☐ American Indian or Alaskan Native
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Native American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ Declined to specify

Ethnicity:

- ☐ Non-Hispanic or Non-Latino
- ☐ Hispanic or Latino
- ☐ Withheld

Smoking

- ☐ Never
- ☐ Former #of packs/day: _____ Months/Years smoked: _____Months/Years since quit: _____
- ☐ Current #of packs/day: _____ Months/Years smoking: _____

Chewing Tobacco/Snuff

- ☐ Never
- ☐ Former #of pouches/day: _____Months/Years chewed: _____Months/Years since quit: _____
- ☐ Current #of pouches/day: _____Months/Years chewing: _____

Allergies/ Drug reactions: _____

_____

Medications/Supplements/Vitamins	Strength/Dosages