



# Cecil Chiropractic & Rehabilitation

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Preferred Language: English Other \_\_\_\_\_

Race: American Indian or Alaska Native Native Hawaiian or Pacific Islander  
 Asian White  
 Black or African-American Other Race  
 Hispanic or Latino Multi-Racial

Current Medications	Strength	Frequency

Allergies?	YES or NO	Severity	Describe Reaction
Medicine:	_____	Mild/mod/severe	_____
Medicine:	_____	Mild/mod/severe	_____
Medicine:	_____	Mild/mod/severe	_____
Medicine:	_____	Mild/mod/severe	_____
Food:	_____	Mild/mod/severe	_____
Environmental:	_____	Mild/mod/severe	_____

Smoking Status (age 13 and over): Current every day smoker Former smoker  
 Current some day smoker Never smoked

### Family History

Full Name	Relationship	DOB	Medical Condition	Age of Condition

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**Clinic Use:**

Height: \_\_\_\_\_ inches

Weight: \_\_\_\_\_ lbs.

Blood pressure: \_\_\_\_\_ / \_\_\_\_\_