Smith Family Chiropractic & Wellness, LLC
230 W. Walnut/P.O. Box 1001
Eunice, LA 70535
(337) 457-1376: Fax (337) 457-1379

DATE: _____

PATIENT: _____

CLINIC: _____

FIRST DAY OF LAST MENSTRUAL PERIOD: _____

I, _____, in signing this form, state to the best of my knowledge, that there is no pregnancy confirmed or suspected at this time.

PATIENT'S SIGNATURE: _____

WITNESS: _____