



Gerken Family Chiropractic

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PERSONAL INFORMATION		
Name: First:	Last:	Middle Initial:
Date:	Home Phone: ()	Cell : ()
Address:		City:
State:	Zip:	Date of Birth:
Email :		
Referred by:		
Goals		
Decrease frequency / intensity of (Pain, Headaches, etc) _____ To / by _____		
Increase range of motion / strength of:		
Improve functional activities of:		
To facilitate stress management and decrease stress levels:		
To improve immune system, endocrine regulation, respiratory or neurological functions:		
To improve education and self-responsibility for health:		
To promote improved balance in the autonomic nervous system to allow for improved relaxation and preventative health:		
To decrease facial restrictions in order to improve bioenergetic alignment, enhance meridian integrity, balance chakras and enhance the assimilation of mental, emotional and spiritual information:		
Other:		

Helping Children, Adults and Families Reach Their Full Potential

Donald G. Gerken, DC, DACCP, CST, Adrienne L. Young, DC, Diane Gerken, DC, Claudette Robbins, LMT