PATIENT HISTORY

Please Print Date: ____________________

Name: ____

Address: ____________________ City: ______________ ST: ____ Zip Code: __________

Phone #: Home ( ) ____________ Work ( ) ____________ Cell ( ) ____________

Birth Date: _________ Age: ________ o Male o Female o Spouse's Name __________

# of Children: ________ o Married o Single o Divorced o Widowed

Employed by: ______________ Work Address: ______________ Occupation: ________

Social Security #: ______________ City, State, Zip: ____________________

Email: ______________________________

How were you referred to our office? ______________________________

Have you ever had Chiropractic Care before? ____________ If yes, when? __________

List your chief complaints in order of severity:

1. ______________________________ For how long? __________
2. ______________________________ For how long? __________
3. ______________________________ For how long? __________
4. ______________________________ For how long? __________

List other Doctors consulted for this condition:

1. ______________________________ Address: ______________
2. ______________________________ Address: ______________

Is this injury or illness work-related? ____________ Have you reported it to your employer? ________

Is this injury or illness related to automobile accident? ________

(If yes, please fill in the following information for YOUR Auto Insurance Company)

Auto Insurance Co: ____________ Policy #: ______________ Claim #: __________

Phone: ( ) ____________ Address: ______________________ Agent: __________

Do you have any type of Health Insurance? ________ Company Name: ______________

Phone: ( ) ____________ Address: ______________ Policy #: ______________

Are you covered under any other group or individual health policy through yourself or spouse?

If yes, Company Name: ______________________________

Address, City, State, Zip: ______________________________

Spouse's Social Security #: ______________________ Employer's Name: ______________

Work Address, City, State, Zip: ______________________________

Method of Payment you plan to use for today's charges: o Check o Cash o VISA o MasterCard

Notice Not all patients require x-rays to determine or verify diagnosis, type and length of care. If your examination warrants an x-ray analysis, the following office policy prevails:

1. All first visits charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be release.

Patient's Signature: ______________________________