CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT Date________________________

Name (Full Legal) ____

Social Security ____________________ Home Phone ____________________

Address ____________________ City ____________ Zip Code __________

Email Address ____________________ Cell Phone ____________________

Age ________ Birth Date ____________ Marital: M S W D How many children? ________

Occupation ____________________ Employer ____________________

Address ______________________________ Office Phone ____________

Guardian or Spouse's Name ____________________ Social Security ____________

Birth Date ____________ Occupation ______________________________

Employer ____________________ Address ____________________

Patient's nearest relative or friend (not living at the same-address) ____________ Phone ________

Address ____

Referred by (doctor, friend, or family member) ____________________

Purpose of this Appointment (major complaint) ____________________

____

Is condition due to injury or sickness arising out of patient's employment? ____________

Date symptoms appeared or accident happened ____________ Have you lost any days from work? ________

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other

Other Doctors seen for this condition: ____________________

Patient ever had same or similar condition? ❑ Yes ❑ No If yes, when and describe ____________

____

Date of last physical examination: ____________ Female: Are you pregnant? ____________

What operations have you had? ____________________

Serious Illnesses? ____________________ Fractured bones? ____________

Have you ever been treated for any health conditions by a physician in the last year? ❑ Yes ❑ No

Describe____

What medications or drugs are you taking? ____________________

Have you ever been under Chiropractic Care? ❑ Yes ❑ No Doctor's Name ____________

HABITS:	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑

DO YOU:

Now take Vitamins or minerals? ❑ Yes ❑ No

Think you may need vitamins or minerals? ❑ Yes ❑ No

Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment ______________________________

Payment: ❑ Cash ❑ Check ❑ Visa ❑ Master Charge ❑ Health Insurance ❑ Worker's Comp. ❑ Auto Med Pay

Health Insurance

Insured's Name ______________________ Insured's Employer ______________________

Insurance Co. ______________________ Group or Policy # ______________________

Address ______________________ Insured's SS# ______________________

Job Injury Information

Date ______________ Time ______________ Injury Reported to Employer? ______________

Description of Accident ______________________________

Name of Workman's Comp. ______________________________

Address of Insurance Co. ______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that nay amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature ______________________________ Date ______________

Guardian or Spouse's Signature Authorizing Care ______________________________ Date ______________

Information Taken By ______________________________ Date ______________

CONDITION	FATHER Age ( )	MOTHER Age ( )	SPOUSE Age ( )	BROTHER(S) Age ( ) Age ( )	SISTERS(S) Age ( ) Age ( )	CHILDREN Age ( ) Age ( ) Age ( )
Arthritis						
Asthma - Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						