



Welcome

| | | |
|---|-------|-----------------|
| Today's Date: ___ / ___ / ___ | | |
| Patient Name _____ | | |
| _____ | _____ | _____ |
| Last | First | Initial |
| What you prefer to be called: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| Birth date: ___ / ___ / ___ Age: _____ SS# _____ | | |
| Mailing Address: _____ | | |
| _____ | _____ | _____ |
| City | State | Zip |
| Home Phone #: _____ | | |
| Work Phone #: _____ | | Ext: _____ |
| Cell Phone #: _____ | | |
| E-Mail Address: _____ | | |
| Referred By: _____ | | |
| Employer: _____ | | How Long? _____ |
| Employer's Address _____ | | |
| _____ | _____ | _____ |
| City | State | Zip |
| Occupation: _____ | | |
| Marital Status: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Seperated <input type="checkbox"/> Widowed | | |
| Spouse's Name: _____ | | |
| Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No | | How many? _____ |

Insurance Information

| | | |
|---|-------|----------------------|
| Co. Name: _____ | | Phone #: _____ |
| Address: _____ | | |
| _____ | _____ | _____ |
| City | State | Zip |
| Insured's Name _____ | | Insured's SS#: _____ |
| Insured's Date of Birth _____ | | ID/Policy # _____ |
| Group # _____ | | |
| Relation to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child | | |
| Insured's Employer: _____ | | |
| Please present your insurance card(s) and driver's license to front desk staff. | | |

Reason for Visit

The reason for this visit is a result of (Please circle): work, sports, auto, trauma or chronic.
Explain what happened: _____

Please describe the pain & its location: _____

When did condition begin? ____ / ____ / ____

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

Is this condition interfering with your (Please Circle): work, sleep, or daily routine?

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone#: _____

In Event of Emergency

Who should we contact? _____

Relation: _____

Home Phone #: _____ Alternate Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

Health History

Are you taking any of the following medications?

- Nerve Pills Insulin Blood thinners Pain Killers (including aspirin)
 Muscle Relax Other(s) Tranquilizers Stimulants

Do you have or ever had any of the following diseases or conditions?

- | | | |
|--------------------------------|-------------------------------|-----------------------|
| Y N Heart Attack / Stroke | Y N Heart Surgery / Pacemaker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves |
| Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N HIV + / Aids | Y N Shingles | Y N Cancer |
| Y N Frequent Neck Pain | Y N Emphysema / Glaucoma | Y N Anemia |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever |
| Y N Severe/Frequent Headache | Y N Kidney Problems | Y N Ulcers / Colitis |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Asthma |
| Y N Diabetes / Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy |
| Y N Lower Back Problems | Y N Artificial Bones / Joints | Y N Arthritis |