

CONFIDENTIAL PATIENT INFORMATION



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Please print.

Name: _____ SS# _____ Date: _____

Birth Date: ___ \ ___ \ ___ Age: _____ Sex: M F Height: _____ Weight: _____ # Children: _____

Marital Status: S M W D Who may we thank for referring you to our office? _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

Spouse Name: _____ SS #: _____ Birth Date: ___ \ ___ \ ___

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

Emergency Contact Name: _____ Phone Number: _____

Current Health Complaints (in order of importance):

1. _____
2. _____
3. _____

Have you ever had same/similar problems before? Y / N If yes, for how long? _____

List of any medications you are currently taking: _____

Are you currently being treated for any other health conditions that we should be aware of? If yes, please explain: _____

Females: Are you pregnant? Y / N / Unsure (please circle one) Date of Last Cycle: _____

If this is an injury sustained for an automotive accident or work related incident, please notify member of the staff immediately. Additional forms may need to be filled out.

Work related? Y / N Was your employer informed? Y / N
Auto Accident? Y / N Date: _____ Do you have an attorney? Y / N Who? _____

Insurance is not required to be a patient in our office. However, if you have insurance that may cover chiropractic care, we would be happy to verify that information for you. Please provide any insurance cards or phone numbers to our staff and we will find the limits of your coverage.

Method of payment for today's charges: Cash Check Charge (please circle one)