Confidential Patient History

Date ___________________

Patient Name _______________________________ Social Security # _______-______-__________

Address _________________________ City ________________ State ________ Zip __________

Age _____ Birth Date _____/_____/_____ Marital Status: M S D W # of Children _______

Home Phone # ( ) _______-__________ Work Phone # ( ) _______-__________ ext. ______

Mobile Phone # ( ) _______-__________ Email Address* _______________________________

Occupation ____________________________ Employer ________________________________

Employer Address ____

Spouse's Name ______________________ Occupation __________________________________

Spouse's Employer ____________________________ Work Phone # ( ) _______-________

Primary Care Physician _____________________________ Phone # ( ) _______-________

Whom may we thank for referring you? ____

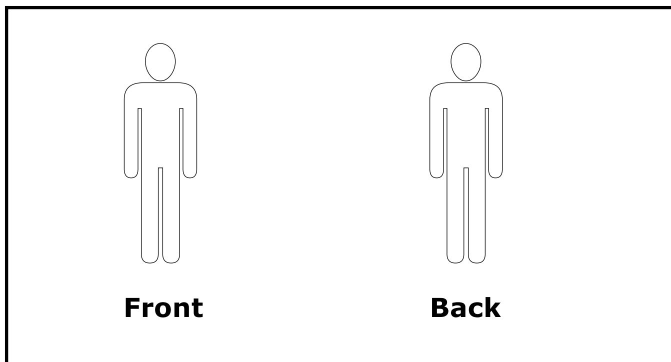
*Your E-mail address is used only for office correspondence and our healthy newsletters.
Your information will never be shared with or sold to third parties, marketing or advertising firms.

Purpose of this Appointment ____

What treatment have you already received for your condition? ☐ Medication ☐ Surgery
☐ Chiropractic Care ☐ Physical Therapy ☐ None ☐ Other ________________________

What medications are you taking? ____

Please mark your areas of pain below:



Women: Are you pregnant at this time?

☐No ☐Yes – Due Date___________

List surgical operations and years:

____

____

Have you ever suffered from:

- ☐ Dizziness ☐ Neck Pain ☐ Heart Trouble
- ☐ Backaches ☐ Diabetes ☐ Nervousness
- ☐ Headaches ☐ Arthritis ☐ Digestive disorders
- ☐ Allergies ☐ Cancer ☐ High Blood Pressure
- ☐ Asthma ☐ Neuritis ☐ Sinus trouble

Date of last physical exam ____________________

By whom _________________________________

List conditions you are interested in getting corrected in order of importance

____

____

____

____

What functions are you unable to perform, or induce pain upon doing so? (example: sit, bend, walk, sleep, etc.)

____

____

____

____

Have you ever had Chiropractic Care before?
☐No ☐Yes - Dr.'s Name ____________________

Have you been treated for any health condition by a physician in the last year? ☐Yes ☐No

If it is determined that your health could be improved, would you want to receive Chiropractic care at this office? ☐Yes ☐No

IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE COMPLETE THIS SECTION:

Is your case: ☐ Workers Compensation ☐ No Fault ☐ Personal Injury

Date of injury:____________Time:___________Location:___________________________________

Please describe how injury happened: ____

____

Did you report your injury? ☐No ☐Yes – To whom? ______________________________________

Were you hospitalized? ☐No ☐Yes – Where? ____

By ambulance? ☐No ☐Yes Were X-rays taken? ☐No ☐Yes – By whom? _____________________

Date(s) of hospitalization____________________ Medication(s) prescribed_____________________

Are you presently working? ☐No ☐Yes – Dates of time lost from work ______________________
Have you been treated by any other chiropractor or physician for this injury? ☐No ☐Yes
If yes, Doctor's name & specialty____

COMMUNICATION CHANNELS:

To help us to better explain your Chiropractic condition and how we may be able to help you, please check the best answer :

1. I remember important things in my life by
☐ what I see. ☐ what I hear. ☐ what I feel.

2. The primary reason I brush my teeth is to
☐ avoid tooth decay and gum disease. ☐ make sure I have healthy teeth and gums.

3. When I make decisions I generally
☐ gather facts and weigh the evidence. ☐ make the right choice instantly.
☐ consult my friends and family. ☐ depend upon how I "feel" about it.

INSURANCE INFORMATION:

Do you have Health Insurance? ☐No ☐Yes – If yes, please continue:

Insurance Co.________________________________ Address_____________________________________

Group #_____________________ID #___________________ Phone number ________________________
Are you covered by any additional insurance? ☐No ☐Yes – If yes, please continue:

Policy Holder's Name____ Birth Date ___/___/___

Insurance Co.________________________________ Address_____________________________________

Group #_____________________ID #___________________ Phone number ________________________

Payment Acknowledgement (Please Sign) – I understand and agree that Health and Accident Insurance policies are an arrangement between insurance carrier and myself. I also understand that this office will prepare any forms and reports necessary to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to 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 to me or my dependent will be immediately due and payable.

Patient's signature ____ Date ____________________

Insured's signature ____ Date ____________________

Parent, Spouse or Guardian Signature________________________ Date ____________________