PATIENT HISTORY

Just what is Chiropractic? Doctors of chiropractic locate and help correct areas of spinal stress (Vertebral Subluxation), a common condition in children and adults. Misaligned spinal bones lose their ability to move and can irritate the spinal cord and nerve roots exiting the spine, disrupting one's health and well-being. Correcting the vertebral subluxation helps restore nerve system performance, thereby allowing the body to function more normally and heal itself.

Thank you for choosing our office!

(PLEASE PRINT)

Name________________________________How were you referred to this office?____________________

Address: ____Social Security **#**____________________
(Apt #) (Street #) (Street) (City), (State) (Zip)

Phone: (hm): ______________ (wk): ______________ (cell): ______________ Email: ______________

Birth Date:__________ Age:_____ Marital Status: S M D W Spouse's Name (or parent):____________________
(M/D/Y)

Ages of Children (under 18): __________ Occupation: ______________ Employer: ______________

Have you ever had Chiropractic care before? NO YES If, "Yes", when last? __________ By whom? __________

For what condition? ____________________Name and Ph.# of Emergency Contact:____________________

LIST YOUR CHIEF COMPLAINTS (IN ORDER OF SEVERITY): ____________________

1. ________________________________ For How long? ____________________

2. ________________________________ For How Long? ____________________

3. ________________________________ For How Long? ____________________

List other doctors consulted for this condition: ________________________________

Is your condition interfering with your work? Home life? Sleep? NO YES (Comments) ____________________

If left uncorrected for 5yrs how would it affect you? ________________________________

Do you have any health problems other than the ones listed? **NO YES** (Explain) ____________________

Is this injury or illness work-related? NO YES Have you reported it to your employer? ____________________

Is this injury or illness related to an automobile accident? NO YES (If yes) Adjustor's Name ______________

Auto insurance Co. ______________ Policy # ______________ Claim # __________ Phone # __________

Do you have any type of Health Insurance? NO YES Company? ________________________________

Address ______________________________ Phone # ______________ Policy # ______________

✸**Are you also covered under any other group or individual health policy through yourself or spouse? NO YES**

If yes, Company's Name ____________________ Phone # __________ Address ____________________

Spouse's Social Security # ______________ Employer ____________________ Phone #______________

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

All first visit charges are payable when services are rendered.

Patient's Signature (or guardian) ________________________________ **Date:**______________