PATIENT HISTORY

(PLEASE PRINT) DATE:_____

Name :_____ Phone H:_____W:_____

Address , City,State,Zip:_____

Birthdate:_____Age_____M/F Spouse Name_____

M/S/D/W: # of Children:_____ S/S #:_____Employed by:_____

Work Address:_____C/S/Z:_____

How were you referred to our office?_____

Have you ever had Chiropractic Care before? _____If yes When?_____

List of your chief complaints in order of severity:

1._____ How long?_____

2._____ How long? _____

3._____ How long? _____

List other Doctors consulted for this condition:

1. _____ Address _____

2._____ Address _____

Is this injury work related? _____ Have you reported it to your employer? _____

Is this injury or illness related to an automobile accident? _____ (If yes , name of YOUR):

Auto Insurance Co. _____Policy #_____Claim#_____

Address: _____ Phone #_____

Do you have any type of Health Insurance? _____ Company _____

Address _____ Phone#_____

Are you covered under any group or individual health policy through yourself or spouse?_____

Address _____

Spouses S/S#_____ Employer _____

Method of Payment you plan to use for today's charges: Check / Cash / Credit card

NOTICE: Not all patients require x-rays to determine or verify a diagnosis, type, and length of care.
If your examination warrants X-ray analysis, the following office policy prevails:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

Patient's Signature: _____

Email: _____