Patient Information

First Name____________________________ Last Name ________________________________

Address________________________________ City__________________ Zip_________

Cell Phone_______________ Home Phone ______________ Work Phone _______________

Birth Date ___/___/____ Sex: M F Marital Status: M S W D Spouse's Name_______________

Social Security #_______________ Occupation______________ Employer________________

Email Address____

Referred By_______________________ Emergency Contact____________________________

Major Complaint

What is your major complaint? ____

Is this condition due to an: A) Auto Accident B) Work Injury C) Other

Date symptoms appeared: __/__/__ How are the symptoms now: Better Same Worse Intermittent

Have you had these symptoms before? ☐Yes ☐No If so, when____________________________

Which activities aggravate your condition? Standing Sitting Bending Lifting Twisting Coughing

Has a physician treated you for any health condition in the past year? ☐Yes ☐No

Please explain____

Do you feel there is any other information that you feel is important to your present condition, or to any medical condition that you have had in the past? ☐Yes ☐No

Desribe____

Are you taking any medication? ☐Yes ☐No Please list each and why__________________________

Females: Is there a chance that you might be pregnant? ☐Yes ☐No

Payment Information

Do you have health insurance that covers chiropractic? ☐Yes ☐No Secondary insurance? ☐Yes ☐No

Primary Insurance Company ____

Insured's Name ___________________________ Insured's Relationship to you_________________

Insured's Birthdate ___/___/___ Insured's Employer___________________________

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment or deductibiles that my insurance does not cover.

Patient's Signature______________________________________ Date______________________