PATIENT HISTORY

Acct.#: _____

Patient's Name: _____ Marital Status: M S W D

Address: _____ Current Age: _____

City, State, Zip: _____ Sex: M F

Home #: _____ Work #: _____ Other #: _____

Patient's D.O.B.: _____ Social Security #: _____

Driver's License #: _____ Employer: _____

Description of type of work you do: _____

Student: Full Time: _____ Part Time: _____ Name of School: _____

Major Complaint / Reason for Visit: _____

Describe your pain: _____

Spouse's Name: _____ Employer: _____

Spouse's Work #: _____ Date of Birth: _____ Social Security #: _____

Emergency Contact: _____ Phone #: _____

How were you referred to this office: _____

INSURANCE INFORMATION: (Please provide ID cards). Please fill out if information is different than from above.

Company Name: _____ Phone #: _____

Insured Name: _____ Relationship: Self Spouse Child

Insured's Address: _____ Phone #: _____

Date of Birth: _____ Social Security #: _____

Please complete:

Is this a Third Party Coverage? _____Yes _____ No Claim #: _____

Do you have Personal Injury Coverage: _____Yes _____No An Attorney? _____Yes _____No

Attorney's Name & Phone #: _____

Mailing Address: _____

CONDITION INFORMATION

Date of injury / Onset: _____ Is this accident related? _____Yes _____No

Related to: _____Auto ____Work _____Other Have you had similar symptoms? _____Yes _____No

If so then when: _____

Were you hospitalized due to this injury? _____ Yes _____ No When: _____

Total / Partial disability due to this injury? _____ Yes _____ No When: _____

Previous chiropractic care? When/Where: _____

TYPE OF CARE REQUESTED

_____ Relief Care - For symptomatic relief of pain or discomfort only.

_____ Corrective Care - Correction for the cause of the problem, as well as the symptoms corrected and relieved.

_____ Comprehensive Care - Detailed care in restoring your body to the highest state of health possible.

_____ Discuss with Doctor and have them select the best type of care for this condition.

Signature: _____ Date: _____

Patient and/or Parent