

Patient History

Today's Date _____

Name: _____ Nickname: _____ Date of Birth _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____ Email: _____

Age: _____ Please Circle: Male or Female Single Married Divorced Widowed # of Children _____

Occupation: _____ Employer: _____ If retired, past occupation: _____

Have you ever had Chiropractic Care before? Yes _____ or No _____ If yes, when? _____

Spouse's information (please provide parent's information if patient is under 18)

Name: _____ Date of Birth: _____ Employer: _____

How did you hear about our office? _____

Females: Are you pregnant? Yes ___ No ___ Maybe ___ Date of last menstrual period: _____

Please list the health issues that brought you here today:

1. _____ For how long? _____ Caused by? _____

2. _____ For how long? _____ Caused by? _____

3. _____ For how long? _____ Caused by? _____

Were any of the above conditions caused by: Auto Accident _____ *please tell receptionist immediately*
Work Accident _____ *please tell receptionist immediately*
Other Accident _____ *please explain: _____*

Other doctors consulted for this condition: _____

Do you have any type of Health Insurance: Y ___ N ___ We will need your card to make a copy.

Method of payment you plan to use for today's charges: Check ___ Cash ___ Visa/Mastercard: ___

NOTICE: Not all patients require x-rays to determine or verify a diagnosis, type, or length of care. If your examination warrants x-ray analysis, the following 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. X-rays may be checked out to another doctor's office, but must be returned within 2 weeks.
3. Your signature below acknowledges that you are aware of our HIPPA policies.
Policies are available from the receptionist upon request.
4. **Patients With Insurance:** Your signature below authorizes the release of any medical or other information necessary to process your claim. It also authorizes payment of medical benefits to our office for services performed in this office.

Patient's Signature (or guardian's signature if patient is under 18)

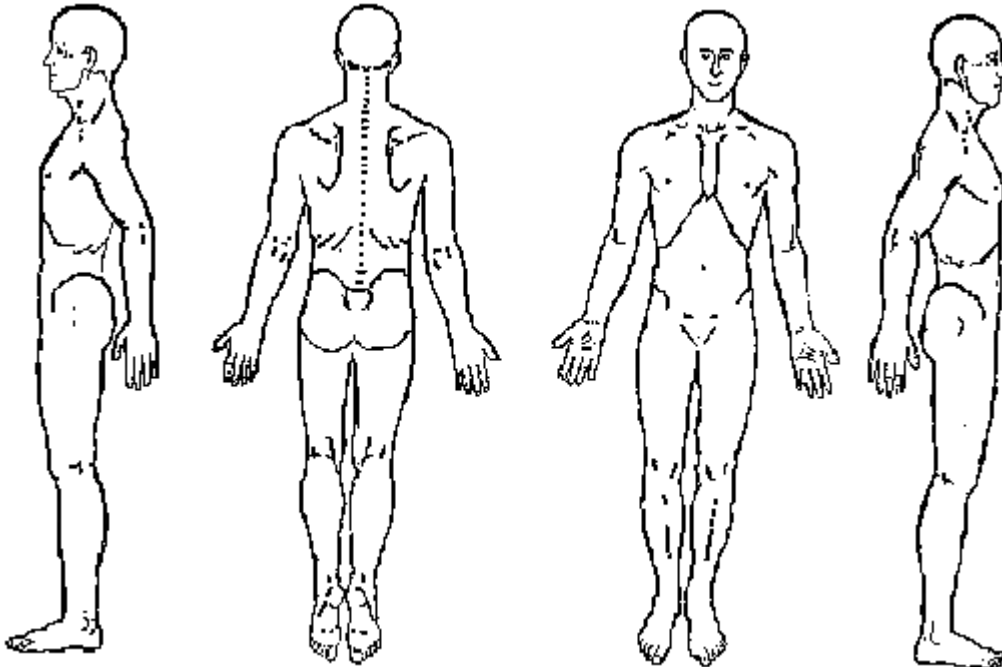
Name _____

Date _____

How long have you had this pain? ___ Years ___ Months ___ Weeks ___ Days ___ Hours

Is this your first episode of this pain? ___ Yes ___ No

Use the letters to indicate the type and location of your sensations right now.



Left

Back

Front

Right

Key:

A=Ache

B=Burning

N=Numbness

P=Pins and Needles

S=Stabbing

O=Other

Other sensations

Please list any serious health conditions you have now or had in the past: _____

Please list any serious accidents or injuries you have had and their dates: _____

Please list any medications you are currently taking and what you are taking them for: _____

Please list any surgical procedures you have had and the dates they were performed: _____

