DATE:

PERSONAL HISTORY

Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip/Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Circle: Married Single Widowed Divorced Separated

Name of Spouse: _____ Referred To This Office By: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill: You and ☐Spouse ☐Worker's Comp ☐Auto Insurance ☐ Medicare ☐Medicaid

☐ Personal Insurance (Name) _____ ☐ Health Card # _____

Insured Person's Name: _____ Date of Birth: _____

I authorize this practice to contact me via text message/phone/email. Yes ☐ No ☐

I authorize this practice to send a progress report to my primary doctor. Yes ☐ No ☐

Name/Address/ Phone number of primary _____

_____

Signature: _____

CURRENT HEALTH CONDITION

Unwanted health condition _____

Other doctors seen for this condition: Yes ☐ No ☐ Who? _____

Type of Treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? Yes ☐ No ☐

Is condition: ☐Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of accident: _____ Time of accident: _____

Have you made a report of your accident to your employer: Yes ☐ No ☐

Drugs you take now: _____

Do you wear a shoe lift? Yes ☐ No ☐

Do you suffer from any condition other than that which you are now consulting us? _____

PAST HEALTH HISTORY

Major Surgery/Operations: ☐ appendectomy ☐ tonsillectomy ☐ gall bladder ☐ hernia ☐ back surgery ☐ broken bones

☐ Other: _____

Major Accident or Fall: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit: _____