

Confidential Patient Information

Welcome to our office! Please complete all questions. Thank you.

(PLEASE PRINT)

Name: _____ Date: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Birth Date: ___/___/___ Age: _____ Social Security #: _____
Sex: M F Marital Status: S M D W
Your Occupation: _____ Your Employer: _____
Spouse's Name: _____ Spouse's Employer: _____
Children's Ages and Names _____
Favorite Hobbies: _____
Emergency Contact: _____ Phone: _____
Who may we thank for referring you? _____
Who is financially responsible for this account? _____
Do you have health insurance? _____ Name of company: _____
Method of Payment For First Visit: (Check one) Cash Check Credit Card

Current health complaints / Reasons for consulting our office (in order of severity):

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

Are these the result of an auto or work related injury? If so, when? _____

Father, mother, brother, sister, children with similar problems? _____

Where is the pain? _____

Does the pain spread? Yes No If yes, where? _____

Is there pain when you cough or sneeze? Yes No If yes, where? _____

Is there pain when you go from a sit to a stand? Yes No If yes, where? _____

Do you experience headaches? Yes No If yes, circle all that apply:
Tension Throb Sinus Migraine Other: _____

Circle any of the following functions below that aggravate or are aggravated by your condition:

Walking Step Climbing Driving Working Recreation Bowel Movements Digestion Vision
Breathing Sinus Problems Hearing Smelling Sleeping **Thinking Clearly** (If female,) Menstrual

Have you ever been to a chiropractor before Yes No If so, when? _____

List other doctors you have consulted for this condition:

1. _____ 2. _____

Previous diagnosis given: _____

Major Surgeries/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia
 Broken Bones Other: _____

Major Accidents or Falls: _____

Medications you currently take: _____

Is there any chance that you are pregnant? Yes No Does not apply

Have you ever been diagnosed with cancer? Yes No If yes, what kind? _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____