Date _____

Name _____ SS# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Address _____ City/State/Zip _____

Date of Birth _____ Age _____ M ____ F ____ Occupation _____

Married ____ Single ____ Divorced ____ Widowed ____ Spouse Name _____ Number of Children _____

When was your last medical care _____ Where _____

When was your last chiropractic care _____ Where _____

When was your last dental care _____ Where _____

Referred by _____

* * * * * * * * * * *

Is This a Personal Injury/Workers Compensation Claim? Yes No Responsible Party _____

Do You Have Health Insurance? Yes No What Company? _____

Who Is Responsible For This Account? _____

* * * * * * * * * * *

Before Accepting You As A Patient The Doctor Will Evaluate Your History And Physical/Laboratory Examination Findings To Assure That Chiropractic Natural Health Care Is The Best Treatment Choice For This Condition.

You (Or Designated Guardian) Will Need To Sign This Lien Of Responsibility

Signature _____ *Date* _____

* * * * * * * * * * *

What Is Your Major Complaint? _____

How Long Have You Had This Condition? _____ Getting Worse? _____ Constant? _____

Pain Comes/Goes? _____ What Aggravates It? _____ Similar Conditions In Past? _____

List Previous Diagnosis/Treatments You Have Received For This Condition _____

What Do You Believe Is Wrong With You? _____

Other Complaints? _____

List Operations And Dates _____

Do You Have A History Of Antibiotic Therapy? _____ Any Allergies? Food _____ Drugs _____

Do You Take: Nerve Pills _____ Pain Killers _____ Pep Pills _____ Muscle Relaxors _____

Birth Control Pills _____ List Over The Counter Pills You Take _____

Have You Been In An Auto Accident In The Last Year? _____ 5 Years? _____ Ever? _____

	ALCOHOL	**COFFEE**	**TOBACCO**	**DRUGS**	**EXERCISE**	**SLEEP**
HEAVY						
MODERATE						
NONE						

List Below The Conditions You Have Been Treated For In The Past Ten Years Or Any Other Health Information You Feel Important:

_____

_____

_____