

CONFIDENTIAL PATIENT INFORMATION

Today's Date _____

Name _____

Soc. Sec. No. _____ Home Phone () _____ Cell Phone () _____

Address _____ City _____ Zip _____

Age _____ Birth Date _____ Martial: M S W D How many children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

DL# _____ State _____

Insured's name if patient is a dependent _____ Soc. Sec. No. _____

Name of Insurance Company _____ Address _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Address _____

Patient's nearest relative _____ Address _____ Phone _____

Referred by _____

Date symptoms appeared or accident happened _____

Patient ever had same or similar condition? Yes No If yes, when and describe _____

Have you lost any days from work? _____

Is condition due to injury or sickness arising out of patient's employment? Yes No

Name of Primary Care Physician _____

Address _____ Telephone _____

Date of last physical exam _____ Female: Are you Pregnant _____

Past surgeries _____

Serious illnesses _____

Have you ever been under Chiropractic Care? Yes No Doctor's Name _____

Purpose of this appointment (Major Complaint _____

What activities aggravate your condition? _____

Is this condition: Constant Comes and goes Getting progressively worse ImprovingIs this condition interfering with your: Work Sleep Daily Routine Other _____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

Other Doctors seen for this condition _____

Have you been treated for any health conditions by a physician in the last year? Yes No

Describe _____

What medications or drugs are you taking? _____

Remarks and additional information _____

