Patient Information

Last Name: _____ First Name: _____ MI: ____ Male/Female (Circle)

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

Email:_____ Home Phone:_____ Cell:_____

Date of Birth: _____/_____/_____ Age: _____ SSN: _____-_____-_____ (Insurance Purposes)

Marital Status: M/S/D/W

Occupation: _____ Employer: _____ Referred By: _____

Spouse Information

Name:_____ Date of Birth:_____/_____/_____ Employer_____

Health History

Date of last physical exam: _____/_____/_____ Height: _____ Weight: _____lbs. Pregnant Y/N?

Describe the purpose of this appointment: _____

Date symptoms started: _____

List any other health problems and treatments: _____

Have you previously received chiropractic care Y/N? How long ago? _____

Do you regularly take any medications Y/N? List medicine and reason you take it: _____

_____

Have you ever had surgery Y/N? Any major falls or accidents Y/N? If yes for either, please list dates and describe:

_____

***Please circle all that apply.*

Musculo-Skeletal System	**Cardio-Vascular Respiratory**	**Nervous System**
Low back problems	Chest Pain	Numbness
Pain between shoulders	Difficult breathing	Dizziness
Neck problems	Painful cough	Fainting
Arm/Leg problems	Rapid heartbeat	Headaches
Swollen/Stiff joints	Blood Pressure problems	Muscle jerking
Sore/Weak muscles	Heart problems	Paralysis
Walking problems	Lung problems	
Broken bones	Pacemaker	

I agree that the following information is accurate and up to date. I authorize the release of any information concerning my health and health care services to any insurance company, health plan, adjustor, or attorney that will assist in the payment of a claim, if applicable.

Patient's Signature: _____ **Date**: _____

If patient is a minor, please sign here for consent to treat: _____