Patient Personal/Confidential Data

Date: ___________ Name: ______________________________ What You Prefer To Be Called: _______________

Home Address: ______________________________________ City/State/Zip ______________________________

Home Phone #: _______________ Cell Phone #: _________________ Email: ___________________________________

Your Date of Birth: __________________ Age: __________ Social Security: ______________________________

Employer Name and Address: ____

How Long? ___________ Occupation: ________________________________ Work Phone #: __________________

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name or Next of Kin: ______________________________ Phone # they can be reached: _______________

Medical Physician's Name: _________________________________ Referred by: ____________________________

Account Responsibility Information

Name of person ultimately responsible for account:

____

Relationship to you: __________________________

Address: ________________________________

SS#: _______________ DL#: ________________

Payment: ☐ Cash ☐ Check ☐ Credit Card

CC# ____________________ Expires: ______/ _____

☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Insurance Info

Please inform the front desk of second insurance source and provide card(s).

Company Name: ____________________________

ID#: ____________________ Group #: ____________

Phone number: ______________________________

Primary Insured Name: _______________________

For Office Use Only

Reason for Visit

What is your major complaint?

____

How did condition develop? _________________________

Date of onset: __________ Have you had same or similar problems in the past? ______________________________

Is this condition getting worse?
Yes No Constant Comes/Goes

How long has it been since you really felt good?

____

What aggravates your condition?

____

Does anything offer relief? __________________________

How would you describe your discomfort?
Sharp Dull Achy Throbbing

What percent of the time does this condition bother you?
0% 25% 50% 75% 100%

How would you rate the level of discomfort on a scale of 0 - 10? (0=no pain 10=extreme pain)? __________

Have you had previous chiropractic care? Yes No

Have you been treated by others for this condition? Yes No

If yes, please list __________________________________