PATIENT INFORMATION:

Name: _____Address:_____

City:_____State: _____ Zip: _____

Home#: _____Work#: _____ Cell#: _____

E-Mail: _____ SS#: _____ Birthday: _____

Age: _____ Male / Female (circle one) Married / Single # OF KIDS _____

Employer: _____ Occupation:_____

How were you referred to our office? _____

Have you seen a Chiropractor before? YES / NO WHEN:_____

LIST YOU SYMPTOMS IN ORDER OF SEVERITY:

(1) _____ How Long?_____
(2) _____ How Long?_____
(3) _____ How Long?_____

List other doctors seen for these symptoms:

(1) _____ Phone #: _____
(2) _____ Phone #: _____

Is this injury work related? YES / NO Was the injury reported to Supervisor? YES / NO

Is this injury an auto accident? YES / NO If so, what insurance is being used? _____

SPOUSE/GUARDIAN INFORMATION:

Name: _____Employer: _____
Occupation: _____ SS#: _____
Work#: _____ Birthday: _____

METHOD OF PAYMENT FOR TODAYS CHARGES:

Check _____ Cash _____ Mastercard _____ Visa _____ Am.Ex._____

IF YOU HAVE MAJOR MEDICAL INSURANCE, PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT DESK.