

PATIENT HISTORY INFORMATION

Name(last) _____ (first) _____ (MI) _____ Phone # _____

Social Sec.# _____ Work # _____ Employer _____

Mailing address _____ City _____ State _____ Zip _____

E-Mail _____ Age ____ DOB ____ / ____ / ____ Sex ____ Referred by _____

Marital Status ____ Emergency Contact _____ Phone # _____

Name and Address of Family Physician _____

Name of Insurance Co. _____ Contract # _____

Have you had chiropractic care in the past? _____ If so for what problem? _____

Were the results satisfactory? ____ Please outline today's purpose for this appointment _____

Is this problem due to an accident/ injury? _____ Date of accident/injury _____

If today's visit is due to an automobile accident-please let the front desk know ASAP-thanks

Description of accident _____

Have you been treated by a Medical Physician for this problem? _____ If so describe treatment _____

List current medication: _____

Past Medical History:

Accidents: _____

Surgeries: _____

Family Medical History (cancer, ect)

Father: _____

Mother: _____

Brother: _____

Sister: _____

Habits:

Do you smoke? _____

Do you drink tea/coffee? _____

Do you drink alcohol? _____

Sign: _____

Date: _____

Mark areas of pain on figures below:

