

Your appt date: _____ **Time:** _____
Referred By: _____ Event: _____

WELCOME ☺

Personal Patient Information - Please Print Clearly

General Information—All your information will remain confidential and is subject to HIPAA privacy laws

Patient's Last name _____ First name _____ Sex: Male Female

Social Security Number ____/____/____ Driver's Lic. # _____ Date of birth _____

Patient's Address _____
Street City, State Zip

Home Phone _____ Cell Phone _____ Native language _____

Email Address _____ (if you have one, please make sure we have this, thanks ☺)

Patient's Employer _____ Full time Part time Retired Student

Employer Address _____ Phone _____
Street City, State Zip

Email Address _____ Would you like to receive a FREE monthly newsletter? Yes No

Married Single Divorced Widowed Spouse's Name _____ # of Children _____

Spouse's Employer _____ Occupation _____ Work Phone _____

******* REFERRED BY : _____ (VERY IMPORTANT) *******

Insurance Information – *If you have insurance, please bring your card with you to this appointment.*

Primary Insurance: CHECK ONE: group private Work. Comp. Automobile

Company Name _____ Policy # _____ Group # _____

Claims Address _____
Street City, State Zip

Claims Phone # _____ Insured's name _____

Insured's Date of Birth _____ Insured's relationship to patient _____

Secondary Insurance (any other health plan covering you) CHECK ONE: group private Work. Comp. Automobile

Company Name _____ Policy # _____ Group # _____

Claims Address _____
Street City, State Zip

Claims Phone # _____ Insured's name _____

Insured's Date of Birth _____ Insured's relationship to patient _____

Your Patient Health History

PLEASE, FILL IN THE APPROPRIATE SPACES. (All information you give is confidential.)

Patient's Name: _____ Today's Date: _____

Major Complaint: _____

How long have you had this condition? _____

Date of Onset? _____

Have you lost workdays? Yes no If yes, how many? _____

Have you had a similar condition before? Yes no If yes, when? _____

Is this condition **accident** related? Auto Work If yes, when? _____

****IF YOU ANSWERED YES TO THE ABOVE QUESTION, STOP & SEE THE FRONT DESK****

When was your last auto accident? _____

When was the one before that? _____

Previous Chiropractic Care? Yes No Chiropractor's name? _____

What was the **reason** for your initial visit? _____

What 'spinal maintenance programs' were *you* given to maximize the future stability of *your* spine? _____

Did you follow it? Yes No if **not**, why? _____

Why are you changing chiropractors? _____

What surgeries have you had? _____

PLEASE, List *any* and *all* **drugs & medications** you now take (prescription and over-the-counter)

Name other doctors you have seen for this condition _____

****What are your health goals?** _____

****How do you expect to achieve them?** _____

