PERSONAL HISTORY

In order for us to give you the best possible service, it is important to get to know you. Please fill out the following forms in detail as completely as you can. THANK YOU!

Is there anyone we may thank for referring you to our office? _____

Date: _____ Social Security No.: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Business phone: _____

Cell phone: _____ Email address: _____

Birthdate: _____ Age: _____ Sex: M F (circle one)

Business/Employer: _____ Type of work you do: _____

Check one: ( )Married ( )Single ( )Widowed ( )Divorced ( )Separated # of Children: ____

Name of Emergency Contact: _____ Phone: _____

Who is responsible for your bill? ( ) Self ( ) Spouse ( ) Workers Comp ( ) Medicare
( ) Auto Insurance ( ) Personal Health Insurance ( ) Other _____

_____

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

Other Doctors seen for this condition: _____

When did this condition begin? _____

If disabled from work, please give dates: _____
( )Job Related ( )Auto Related

PAST HEALTH HISTORY

Please check or describe:

Major Surgery/Operations: ( ) Appendectomy ( ) Tonsillectomy ( ) Hernia

( ) Gall Bladder ( ) Other: _____

( ) Broken Bones: _____

Major Accidents or Falls: _____

_____

Hospitalizations (other than above): _____

_____

Have you had previous Chiropractic care? ( ) Yes ( ) No

If yes, please give Doctor's name and approximate date of your last visit: _____

_____

Have you been treated for any health condition in the last year? ( ) Yes ( ) No

If yes, please give full details: _____

_____

_____

_____

_____