For Office Use Only: ACCT #:________________
NP________ EP________

CONFIDENTIAL PATIENT INFORMATION

(Please Print Clearly) Date: ________________

Name: ______________________________. Home Phone: ______________
Cell Phone: ______________

Home Address______________________. City __________ State ____ Zip______

E-Mail Address: ______________________________. SS#: XXXXXXXXX

Occupation: ______________ Employer: ______________________

Work Address: ______________________________. Work phone: ______________

Birth Date: ________ Age____. Sex: M F Marital Status: S M W D. Spouse's Name:__________

Names of Children & Ages ____

____

How were you referred to our office? ______________________________________

Have you ever been to a chiropractor before? _______. If so, when? ____________________

List your chief complaints in order of severity:

1. ______________________________________. For how long?____________
2. ______________________________________. For how long? ____________
3. ______________________________________. For how long?____________

List other doctors consulted for these conditions:

1. ____________________. Address:______________________________
2. ____________________. Address:______________________________

List the medication(s) you are currently taking:

1. __________________________. 4. __________________________
2. __________________________. 5. __________________________
3. __________________________. 6. __________________________

Cause of complaints/symptoms (Please circle): 1) Work related injury 2) Auto accident 3) Other

Goal Question: If you could accomplish one important thing or mission for your life, what would that be?

____

PRIMARY INSURANCE: (Group ____ Work Comp ___ Auto____ Other____)

Insurance Co.:______________________ Name of *Insured*:______________________

Claim # or Policy#:______________________________ Group #: ______________

Females: Are you pregnant? Yes_________ No_________ Not sure________

Please notify the doctor if you are pregnant or possibly pregnant.

(Over)