

**CONFIDENTIAL PATIENT INFORMATION**

(Please Print Clearly)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ SS#: \_\_\_\_\_

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)

