

Welcome

Health and Insurance Information

Patient Information

Name _____ Date _____ File # _____
Last First MI
Address _____ City _____ State _____ Zip _____
Birthdate: ____/____/____ Age: ____ S/S _____
Home Phone # _____ Do you prefer to receive calls at:
Work Phone# _____ ext. _____ Home ___ Work ___ None ___
Other Phone# _____ E-Mail Address _____
Are you : Minor Single Married Divorced Do you have children? Y N - How many? ____
Employer _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____
Spouse or Parent name _____
Emergency contact: _____ Phone # _____ Relationship _____
Referred By: _____

Insurance Information

Primary Insurance:

Insurance Co. _____ Group # _____
Insurance Address _____ City _____ State _____ Zip _____
Insured's Name _____ Birthdate ____/____/____ S/S _____
Relationship to patient _____

Secondary Insurance:

Insurance Co. _____ Group# _____
Insurance Address _____ City _____ State _____ Zip _____
Insured's Name _____ Birthdate ____/____/____ S/S _____
Relationship to patient _____

Reason for Visit

The reason for this visit is a result of (please circle): Work, Sports, Auto, Trauma or Chronic
Explain what happened: _____

Describe the pain and location _____

When did condition begin ____/____/____ Is the condition getting worst? Y_ N_ Constant ___ Comes and goes ___

Is this condition interfering with (please circle): Work, Sleep, or Daily routine

If so please explain: _____

Has this happened in the past? Y ___ N ___

If so please explain: _____

Have you been treated by a Medical Phy. For this condition? Y ___ N ___

If so, where? _____

Have you ever been treated by a Chiropractor before? Y ___ N ___

If so, whom? _____ Phone _____