

1 *one* WELCOME

ABOUT YOU

Today's Date ___/___/____. File #: _____
Name : _____
What You Prefer to Be called : _____ Male Female
Birth date: ___/___/___ Age: ___ SS#: _____
Home Address: _____

CITY STATE ZIP
Home Phone #s: _____
Other Phone #s: _____
E-Mail Address: _____
Referred By: _____
Employer: _____ How Long? _____

CITY STATE ZIP
Occupation: _____ Work Phone #: _____
Marital Status: Single Married Divorced Separated Widowed
Spouses Name: _____

2 *two*

INSURANCE INFO

Co. Name: _____
Address: _____
Phone: _____
Insured's SS #: _____
Group # (Plan, Local, or Policy #) _____
Insured's Name: _____
Relation: _____ Date of Birth: ___/___/___
Insured's Employer: _____
Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? YES NO
If so please explain: _____
The reason for this visit is a result of (please circle): work, sports, auto, trauma or chronic:
(Explain what happened): _____

Please describe the pain & its location: _____

When did condition begin ? ___/___/___
Is this condition getting worse ? Yes No Constant Comes and goes
Is this interfering with your (Please circle): work, sleep, or daily routine
If so please explain: _____
Have you had this or similar conditions in the past ? Yes No
If so, please explain: _____
Have you been treated by a Medical Physician for this condition? Yes No
If so, where? _____

3 *three*

PLEASE CONTINUE ON BACK