CONFIDENTIAL PATIENT INFORMATION

Name: _____ Maiden Name: _____ Referred By: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Alternate Phone: _____
Birth date: _____ Email _____
Martial Status: M DP S W D Spouse/Partner's Name: _____
If Accident: Date: _____ Location: _____
How would you like to pay for care? ☐ Medical Ins. ☐Cash ☐Work Comp ☐Auto Ins.
Occupation: _____ Work Phone: _____
Employer: _____ Work Address: _____
Spouse's Occupation: _____ Employer: _____
Spouse's Work #: _____ Alternate #: _____
Emergency Contact *(Other than someone you live with.)* _____
Relation: _____ Home #: _____ Work #: _____

Medical History:

Major Complaint: _____
If result of injury or fall, please describe: _____
_____
How long have you had this condition? _____ Days lost from work? _____
Ever had a similar condition in the past? ☐Yes ☐ No Treated for? _____
Is this condition getting progressively worse? ☐Yes ☐No ☐Constant ☐Comes & Goes
Does this condition interfere with: ☐Work ☐Sleep ☐Daily Routine ☐Other _____
What do you believe the problem is? _____
Has a physician treated you for any other health condition in the past year? ☐Yes ☐No
Describe: _____
List any serious illness: _____
List medications/drugs you are taking: _____
Have you ever been treated with: ☐Chiropractic ☐Acupuncture ☐Massage

Have you ever suffered from: *(Please list dates)*

Dizziness: _____	Arthritis: _____	Asthma: _____
Backaches: _____	Headaches: _____	Nervousness: _____
Heart Trouble: _____	Numbness: _____	Sinus Trouble: _____
Digestive Disorders: _____	Neuritis: _____	Anemia: _____
Tuberculosis: _____	Diabetes: _____	Cancer: _____

Patient's Signature: _____ Date: _____

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