

PATIENT INFORMATION

Please print and answer the following questions as accurate and complete as possible.

Today's Date: _____

PERSONAL INFORMATION

Legal Name: _____ Age: _____ Sex:

M F

(First) (MI) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Date of Birth: ____/____/____ SS# ____-____-____

Business/Employer: _____ Work Phone: _____

Type of Work Performed: _____ Marital Status: M S

W D

Spouse's Name: _____ Children? Sons: _____ Dau: _____

Emergency Contact: _____ Phone: _____

Who is Your Family Physician? _____ City: _____ State: _____

How did you hear about this office? _____

CURRENT HEALTH CONCERNS

Reason For Today's Visit: _____

Is Condition: Job Related Auto Related Injury Other: _____

Past Health History

Major Surgeries/Operations: Head Neck/Throat Chest/Heart/Lung

Back Abdominal Other: _____

Previous Fractures or Broken Bones: Yes No What: _____

Previous Falls or Accidents:..... Yes No When: _____

Previous Hospitalization:..... Yes No Why: _____

Previous Chiropractic Care:..... Yes No Doctor: _____

Previous Spinal X-rays/MRI/CT..... Yes No Where: _____