

1 one

WELL COME

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Name: _____

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Home Address: _____

CITY _____ STATE _____ ZIP _____

Home Phone #: _____

Other Phone #s: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY _____ STATE _____ ZIP _____

Occupation: _____ Work Phone#: _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name: _____

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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 condition 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? _____

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PLEASE CONTINUE ON BACK

