

PATIENT CODE

ACQUAINTANCE INFORMATION

THE DATA ON THIS CONFIDENTIAL FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST PROFESSIONAL CARE. WE APPRECIATE YOUR CO-OPERATION IN FILLING IT OUT SO THAT WE WILL HAVE ACCURATE RECORDS.

PLEASE PRINT - THANK YOU.

PERSONAL INFORMATION

PATIENT'S LAST NAME		FIRST NAME	MIDDLE NAME	HOME PHONE
MAILING ADDRESS			CITY/TOWN	POSTAL CODE
DATE OF BIRTH DD MM YY	OCCUPATION	EMPLOYER		BUSINESS PHONE
BUSINESS ADDRESS				CELL PHONE:
MARITAL STATUS	NAME OF SPOUSE	# OF CHILDREN	OCCUPATION	EMAIL ADDRESS
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?			BY WHOM WERE YOU REFERRED?	

HEALTH INSURANCE PLAN

Do you have an extended health insurance plan through your place of work? (Benefits) Yes No If Yes, Name of Insurance Company _____

CHIROPRACTIC HEALTH INFORMATION

(Please circle your answer to each question. If yes, please explain)

Have you had previous chiropractic care? Yes How long ago? _____ No _____

Doctor _____ Address _____

What were you treated for? _____ Were X-rays taken? Yes No

What is your major complaint? _____

What makes it feel better? _____

How long have you had this condition? _____

Have you had this or a similar condition in the past? Yes No When? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No When? _____

Is this condition interfering with your: Work Sleep Daily Routine Other _____

Other complaints: _____

(Please List) _____

Have you ever been in an auto accident? Yes No When? _____

Have you had surgery? Yes No Please List _____

Interests & Hobbies: _____

Are you currently taking? Birth Control Pills Insulin Muscle Relaxants Painkillers

List other medications _____

Have you ever suffered from:

- Arthritis Yes No _____
- Asthma Yes No _____
- Backaches Yes No _____
- Diabetes Yes No _____
- Digestive Disorders Yes No _____
- Dizziness Yes No _____
- Headaches Yes No _____
- Heart Trouble Yes No _____
- Neck Pain Yes No _____
- Neuritis Yes No _____
- Nervousness Yes No _____
- Sinus Trouble Yes No _____
- Other _____

Please mark your areas of pain on the figures shown below.

