CONFIDENTIAL PATIENT HISTORY Date_____

PATIENT'S NAME_____SOCIAL SECURITY#_____

ADDRESS _____CITY _____STATE ____ZIP_____

AGE_____BIRTH DATE_____MARITAL STATUS: M S D W # CHILDREN_____

HOME PHONE #_____ **CELL PHONE #_____CIRCLE** PREFERRED #

OCCUPATION_____ EMPLOYER_____

SPOUSE NAME_____REFERRED TO OFFICE BY_____

EMAIL ADDRESS:_____

Do you authorize this office to send you emails: □**YES** □**NO** **Please Initial_____**
Do you authorize this office to send you Text Appointment Reminders: □**YES** □**NO** **Please Initial_____**
If "YES" please provide Cell Carrier: □ AT&T □Verizon □Sprint □Boost Mobile □Other _____

RACE: □WHITE □ASIAN □AFRICAN AMERICAN □HISPANIC □OTHER_____ □DECLINE

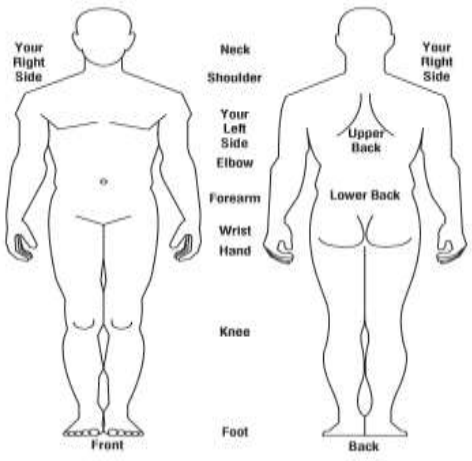
ETHNICIY: □HISPANIC OR LATINO □NOT HISPANIC OR LATINO □DECLINE

PREFERED LANGUAGE: □ENGLISH □SPANISH □OTHER_____

Purpose of this appointment_____

Have you seen any physician for this condition? _____ Chiropractor _____MD _____None

Please mark your areas of pain below:



Women: Are you pregnant at this time?

□Yes □No

List Surgical Operations and Years
No surgeries, check here □

_____

_____

Have you ever suffered from:

□ Dizziness	□ High blood press.	□ Neuritis
□ Backaches	□Diabetes	□ Nervousness
□ Headaches	□ Arthritis	□ Digestive disorders
□ Heart trouble	□Asthma	□Sinus trouble
□Allergies	□Cancer	□Neck pain

Date of last physical exam_____

By whom_____

List conditions that you are most interested in correcting. List in order of importance.

1_____

2_____

3_____

4_____

What functions are you unable to perform, or induce pain upon performance?

(example: sit, bend, walk, sleep, etc.)

1_____

2_____

3_____

4_____

Have you ever had Chiropractic care before

□Yes □No

Doctor's name_____

Have you been treated for any health condition by a physician in the last year? □Yes □No

Please describe_____

_____

Do you currently smoke tobacco of any kind? □**Yes** □**Former Smoker** □**Never been a smoker**
If yes, how often do you smoke □Current every day smoker □Current sometimes smoker
If yes, what's your level of interest in quitting smoking? **No interest** 0 1 2 3 4 5 6 7 8 9 10 **Very interested**

Current medication If there are no current medications, check here □

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

List any known allergies (Medication, Food and or Environment)If there are no current allergies, check here □

1._____ 3._____
2._____ 4._____

Has any doctor diagnosed you with Hypertension presently? □YES □NO
If yes please describe:_____

Has any doctor diagnosed you with Diabetes presently? □YES □NO □TYPE I □TYPE II
If yes, other comments regarding diabetes:_____

Alcohol Consumption Circle One: None Casual Moderate Heavy

Caffeine Consumption Circle One: None <3cups/day 3-6 cups/day >6 cups per day
(Coffee, Tea, Soda)

Relative	**Living Age**	**History**	**Deceased Age**	**Cause of Death**
Father				
Mother				
Brother(s)				
Sisters(s)				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

IF YOUR CONDITION IS THE RESULT OF WORKERS' COMP OR NO FAULT FILL OUT:

IS YOUR CASE: ____Workers Compensation ____No Fault (car accident)

Date of Injury: Time: _____ Location:_____

Please describe how injury happened_____

_____

Did you report your injury? □Yes □No To whom?_____

Were you hospitalized? □Yes □No Where?_____

By ambulance? □Yes □No X-Rays taken? □Yes □No By whom?_____

Date(s) of hospitalization_____ Medications prescribed_____

Are you presently working? □Yes □No Dates of time lost from work_____

Have you been treated by any other chiropractor or physician for this injury? □Yes □No

If yes, Doctor's name & specialty_____

INSURANCE INFORMATION: (PLEASE PRINT)

Do You Have Health Insurance? □Yes □No If yes:

Primary Insurance Company_____

Address_____ Policy #_____

Secondary Insurance Company name

_____

Address_____ Policy #_____

PAYMENT ACKNOWLEDGEMENT (PLEASE SIGN)

I understand and agree that Health and Accident Insurance policies are an arrangement between an insurance carrier and myself. I also understand that this office will prepare any forms and reports necessary to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me or my dependent with immediately due and payable.

Patient's signature_____ Date_____

Insured's signature_____ Date_____

Parent, Spouse or Guardian's signature_____ Date_____