CONFIDENTIAL PATIENT INFORMATION:

NAME_____DATE_____

ADDRESS_____CITY_____ZIP_____

AGE_____ DOB_____ HT_____ WT_____ MARITAL STATUS M S W D

PHONE (H)_____(W)_____(CELL)_____

E-MAIL_____EMPLOYER_____

EMERGENCY CONTACT:_____PHONE_____

INSURANCE COMPANY INFORMATION IN FILE_____COPY OF CARD_____

CHIEF COMPLAINT_____

HOW LONG <u>HAS THIS EPISODE</u> AFFECTED YOU?_____

How Many episodes have you had in the past? _____ When? _____

IS THIS DUE TO: AN INJURY? _____ ON THE JOB?_____ AUTO?_____

HAVE YOU LOST ANY DAYS OF WORK?_____ WHEN?_____

OTHER DOCTORS SEEN FOR THIS CONDITION?_____

WHAT DO YOU BELIEVE IS WRONG WITH YOU?_____

COMPLAINTS OTHER THAN CHIEF COMPLAINT_____

HAVE YOU RECEIVED CHIROPRACTIC CARE PREVIOUSLY?_____

WHAT MEDICATIONS DO YOU CURRENTLY TAKE?_____

_____

PLEASE LIST ALL PAST FRACTURES, SURGERIES, OR INJURIES:_____

_____

IS THERE ANY OTHER MEDICAL CONDITION YOU THINK WE SHOULD KNOW ABOUT?_____

_____

What type of treatment are you looking for?

_____ I'm looking for the most minimal amount of care to "patch up the symptoms" of my problem.
_____ I'm looking to resolve my symptoms and to "fix the cause" of my problem.
_____ I'm looking to take care of my problem and the go on to achieve optimal health and wellness.

WHO MAY WE THANK FOR YOUR REFERRAL?_____

PATIENT SIGNATURE_____ DATE_____ INFORMATION TAKEN ___