PATIENT HISTORY

In order to help us render the proper Chiropractic services to you. Please answer the following questions, fill in the blanks when indicated. All information provided is for our records and **considered confidential.**

Patients Name ____ Date ________________
Last First Middle

Address____
Number Street City State Zip

Home Phone _____________________________Cell Phone _______________________________

Business Phone ___________________________Email __________________________________

Occupation _________________________ Employed by _________________________________

SS# ___________________DOB __________________Driver's License ______________________

Insurance Company ______________Spouse Name ____________________DOB _______________

Marital Status: Single ☐ Married ☐ Spinal Health: Excellent ☐ Fair ☐ Poor ☐

Name of MD _______________________ Formal Chiropractor _____________________________

Whom may we thank for referring you? ____

Reason for visit ____

Medical Conditions/Domestic Abuse ____

Have you ever had a head or neck injury? Describe____

____

Date of injury ____________ Are you Pregnant? ______ Do you exercise? ____________________

Describe Exercises ____

Describe All Surgeries ____

Scale of 1-10 (**10 highest**) what number would you give your pain? **1 2 3 4 5 6 7 8 9 10**

Patients' Signature ____

PLEASE COMPLETE OTHER SIDE: ➡

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