

PATIENT HISTORY

TODAY'S DATE _____

FULL NAME _____ SEX (M or F) _____

STREET ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____

EMPLOYER _____ ADDRESS _____

JOB DESCRIPTION _____

SOCIAL SECURITY # _____ BIRTHDATE _____ AGE _____

MARITAL STATUS _____ SPOUSE'S NAME _____

DO YOU HAVE ANY CHILDREN? _____ NAMES AND AGES _____

REFERRED BY _____

PRIMARY INSURANCE _____ NAME OF INSURED _____

SECONDARY INSURANCE _____ NAME OF INSURED _____

DATE OF LAST PHYSICAL EXAM _____ SURGURIES _____

LIST FRACTURES AND DATES _____

LIST ALL MEDICATIONS YOU ARE TAKING _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS IN THE LAST YEAR?

YES or NO _____ IF YES, DESCRIBE: _____

WHAT X-RAYS HAVE YOU HAD IN THE LAST FIVE YEARS? _____

WOMEN: IS THERE ANY POSSIBILITY YOU ARE PREGNANT? _____

CHIEF COMPLAINT(S): _____

DATE SYMPTOMS APPEARED OR WHEN ACCIDENT HAPPENED _____

HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? YES or NO _____

IF SO, DESCRIBE: _____

IS THIS PRESENT CONDITION THE RESULT OF A WORK-RELATED INJURY? _____

DID YOU NOTIFY YOUR EMPLOYER? _____ DATE _____ NAME _____

IS THIS CONDITION THE RESULT OF AN AUTOMOBILE ACCIDENT? YES or NO _____

IF YES, DESCRIBE WHAT HAPPENED: _____

People go to Chiropractors for a variety of reasons. Some go for symptoms of pain or discomfort (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (PREVENTIVE CARE). These are the three phases of Chiropractic Care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, his prepared recommendation is an incorporation of all three phases.

Please check the type of care you desire so that we may be guided by your wishes whenever possible.

_____ Relief Care _____ Corrective Care _____ Preventive Care _____ Doctor's Recommendation

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand the Chiropractic LifeCenter will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Chiropractic LifeCenter 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 at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Chiropractic LifeCenter to obtain a credit report if necessary.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

In case of emergency, notify _____

Name of closest relative not living with you

Relationship (i.e. Mother, Father, ect.) _____

Address _____

Phone _____