PATIENT HEALTH RECORD

This information is important and confidential. Please PRINT and SIGN this form at the bottom. Thank-you.

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ CELL # _____

EMAIL _____ S.S. # _____

OCCUPATION _____ EMPLOYED BY _____

MARITAL STATUS: S M W D IF MARRIED, NAME OF SPOUSE _____

NUMBER OF CHILDREN
AT HOME & AGES _____ REFERRED BY _____

Are you interested in knowing about our "Family Plan" so that you and your family can maintain better health?
❑ YES ❑ NO

YOUR PRESENT HEALTH COMPLAINT (if any) _____

_____

HOW & WHEN DID THIS PROBLEM START? _____

_____

LIST, WITH DATES, ANY OTHER DOCTORS OR HOSPITALS YOU HAVE VISITED FOR THIS: _____

_____

PAST HEALTH RECORD

ANY PREVIOUS ILLNESSES? (if so, please explain) _____

_____

LIST ANY & ALL OPERATIONS _____

ANY FRACTURES OR DISLOCATIONS? (if so, please explain) _____

_____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? (please explain) _____

_____

ARE YOU TAKING ANY MEDICATION AT THIS TIME FOR ANY REASON? (please explain) _____

_____

PLEASE LIST NAME OF YOUR PRESENT HEALTH INSURANCE _____

PLEASE WRITE BELOW ANY ADDITIONAL INFORMATION THAT YOU FEEL THE DOCTOR SHOULD KNOW:

_____

_____

_____

SIGNATURE _____