CONFIDENTIAL PATIENT HISTORY

(PLEASE PRINT)

Date _____

PATIENT'S NAME _____ SOC SEC # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL STATUS: M S D W # CHILDREN _____

HOME PHONE # _____ WORK PHONE # _____ CELL: _____

OCCUPATION _____ EMAIL ADDRESS: _____

EMPLOYER ADDRESS _____

SPOUSE'S NAME _____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ WORK PHONE _____

REFERRED TO THIS OFFICE BY _____

_____

_____ Chiropractor _____ MD _____ None

_____

List conditions that you are most interested in getting corrected. 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 _____

_____

_____