

DATE _____

PATIENT HISTORY & EXAMINATION

NAME _____ PHONE () _____ CELL PHONE () _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HT. _____ WT. _____ AGE _____ BIRTHDATE _____ MARITAL STATUS: M S W D NO. CHILDREN _____

SOCIAL SECURITY # _____ DRIVERS LICENSE # _____

OCCUPATION _____ EMPLOYED BY _____ PHONE () _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

REFERRED BY _____

ACCIDENT – INJURY INFORMATION:

DATE OF ACCIDENT _____ TIME _____ AM PM WAS EMPLOYER NOTIFIED? _____ LAST DAY WORKED? _____

ACCIDENT LOCATION & DESCRIPTION _____

PREVIOUS TREATMENT FOR THIS CONDITON:

_____ DC _____ MD OTHER _____ NAME _____

RESULTS _____

HAVE YOU BEEN PLACED ON DISABILITY? _____ BY WHOM? _____

HEALTH HISTORY: IMPORTANT- LIST DRUGS YOU ARE NOW TAKING _____

DO YOU HAVE? TB _____ VD _____ IN THE PAST _____ CANCER _____ DIABETES _____

SURGERY HISTORY:

_____ Appendix _____ Tonsils _____ Hernia _____ Hemorrhoid _____ Spinal _____ Hysterectomy _____ Prostate _____ Cyst _____ Cancer

LIST OTHERS _____

LIST FRACTURES / DISLOCATIONS / CONCUSSIONS PRESENT & PAST _____

LIST PREVIOUS ACCIDENTS / INJURIES / MAJOR ILLNESSES _____

FAMILY PHYSICIAN _____ TELEPHONE () _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NEAREST RELATIVE (Not living with you) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE () _____ RELATIONSHIP _____

PAYMENT ARRANGEMENTS ARE EXPECTED BEFORE SERVICES ARE RENDERED:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Office 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____