PATIENT CODE

ACQUAINTANCE INFORMATION

THE DATA ON THIS CONFIDENTIAL FORM IS ESSENTIAL IF WE ARE TO RENDER THE BEST PROFESSIONAL CARE.
WE APPRECIATE YOUR CO-OPERATION IN FILLING IT OUT SO THAT WE WILL HAVE ACCURATE RECORDS.

PLEASE PRINT - THANK YOU.

PERSONAL INFORMATION

PATIENT'S LAST NAME	FIRST NAME MIDDLE NAME		HOME PHONE
MAILING ADDRESS		CITY / TOWN	POSTAL CODE
DATE OF BIRTH DD | MM | YY	OCCUPATION	EMPLOYER	BUSINESS PHONE
BUSINESS ADDRESS			CELL PHONE:
MARITAL STATUS	NAME OF SPOUSE # OF CHILDREN	OCCUPATION	EMAIL ADDRESS
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?			BY WHOM WERE YOU REFERRED?

HEALTH INSURANCE PLAN

Do you have an extended health insurance plan through your place of work? (Benefits) ☐ Yes ☐ No If Yes, Name of Insurance Company _____

CHIROPRACTIC HEALTH INFORMATION

(Please circle your answer to each question. If yes, please explain)

Have you had previous chiropractic care? ☐ Yes How long ago? _____ ☐ No _____

Doctor _____ *Address* _____

What were you treated for? _____ *Were X-rays taken?* ☐ Yes ☐ No

What is your major complaint? _____

What makes it feel better? _____

How long have you had this condition? _____

Have you had this or a similar condition in the past? ☐ Yes ☐ No When? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No When? _____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

Other complaints: _____

(Please List) _____

Have you ever been in an auto accident? ☐ Yes ☐ No When? _____

Have you had surgery? ☐ Yes ☐ No Please List _____

Interests & Hobbies: _____

Are you currently taking? ☐ Birth Control Pills ☐ Insulin ☐ Muscle Relaxants ☐ Painkillers

List other medications _____

Have you ever suffered from:

Arthritis	☐ Yes ☐ No	_____
Asthma	☐ Yes ☐ No	_____
Backaches	☐ Yes ☐ No	_____
Diabetes	☐ Yes ☐ No	_____
Digestive Disorders	☐ Yes ☐ No	_____
Dizziness	☐ Yes ☐ No	_____
Headaches	☐ Yes ☐ No	_____
Heart Trouble	☐ Yes ☐ No	_____
Neck Pain	☐ Yes ☐ No	_____
Neuritis	☐ Yes ☐ No	_____
Nervousness	☐ Yes ☐ No	_____
Sinus Trouble	☐ Yes ☐ No	_____

Other _____

_____

Please mark your areas of pain on the figures shown below.