

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 # _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER ADDRESS _____

SPOUSE'S NAME _____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ WORK PHONE _____

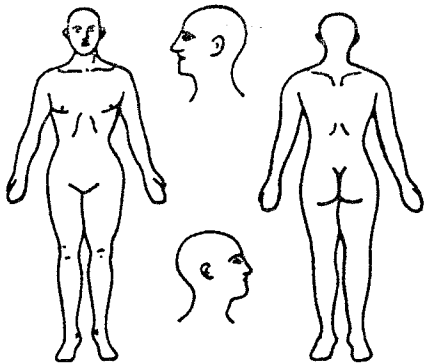
REFERRED TO THIS OFFICE BY _____

Purpose of this appointment _____

Have you seen any physician for this condition _____ Chiropractor _____ MD _____

What medications are you taking? _____

Please mark your areas of pain below:



Women: Are you pregnant at this time?
___ Yes ___ No

List surgical operations and years

Have you ever suffered from:

- Dizziness High blood press Neuritis
- Backaches Diabetes Nervousness
- Headaches Arthritis Digestive disorders
- Heart trouble Asthma Sinus trouble
- Allergies Cancer Neck pain

Date of last physical exam _____

List conditions that you are most interest getting corrected. List in order of importa

- 1 _____
- 2 _____
- 3 _____
- 4 _____

What functions are you unable to perform induce pain upon performance? (example bend, walk, sleep, etc.)

- 1 _____
- 2 _____
- 3 _____
- 4 _____

Have you ever had Chiropractic care befo
 Yes No

Doctor's name _____

Have you been treated for any health cor by a physician in the last year? Yes No

If it is determined that your health cc improved, would you want to receive chirc care at this office? Yes No