Confidential Patient Health Record Date:_____

Personal History

Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Birth Date:_____ Age:____ Sex: M F

Work Phone:_____ Driver's License #:_____

Cell Phone:_____ Social Security #:_____

Business Phone:_____ Type of Work:_____

Name of Spouse:_____ Circle One: Married Single Divorced

Spouses Employer:_____ Business Phone:_____

Type of Work:_____ Name & Ages of Children:_____

Referred by:_____ _____

Name & Number of Emergency Contact:_____

Relationship:_____

Who is responsible for your Bill, You, Worker's Comp, Auto Insurance? _____

Medicare Medicaid Personal Health Insurance: (Name):_____

Do you have an Attorney? Yes No If Yes, who?_____

Insured Person's Name:_____ Date of Birth_____

E-Mail Address_____

Current Health Condition

Main Complaint:_____

Other Doctors seen for this condition? Who?_____

Type of Treatment:_____ Results:_____

When did this condition begin?_____ has this condition occurred before? Yes No

Date of Accident:_____ Time of Accident:_____

Have you made a report to your Employer? Yes No

Have you made a report to your Insurance Company? Yes No

Drugs you now take? Nerve Pills Pain Killers/Muscle Relaxers Blood pressure medicine

Insuline Other:_____

Are you pregnant? Yes No

Do you suffer from any conditions other than which you are now consulting us?_____

Past Health History

Any Surgeries/Operations: Appendectomy Tonsillectomy Gall bladder Hernia Back surgery Broken Bones other:_____

Major Accidents or falls:

_____

_____

Hospitalizations (other than above)_____

Previous Chiropractic Care: No Yes, If yes Doctor's Name and Approximate Date of last visit:

_____

Who referred you to our office?:_____