PERSONAL HISTORY

Date:_____ Case Number:_____
Name:_____ Address:_____
City:_____State:_____ Zip:_____
Home Phone:_____ Business Phone:_____
Cell Phone:_____ E-Mail Address:_____
Birth date:_____ Age:_____Sex: M F Height:_____Weight:_____
Employer:_____ Type of Work:_____
Check One: □ Married □ Single □Widowed □ Divorced □Separated
SS:_____ Spouses SS#:_____ No. of Children:_____
Referred To This Office By:_____
Who Is Responsible For Your Bill: You and: □ Spouse □ Workman's Compensation □ Medicare
□ Auto Insurance □ Personal Health Insurance □ Other _____
In Case Of Emergency Contact: Name: _____ Relation: _____
Home Phone: _____ Cell Phone:_____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____
Major Complaint: _____
Other Doctor's Seen For This Condition: _____
When Did This Condition Begin: _____
Are There Others In Your Family With This Same Condition:_____
If Disabled From Work Please Give Dates:_____
□ Job Related □ Auto Related □ Date of Accident/Injury:_____
Medication You Now Take: □Nerve Pills □Pain Killers/Muscle Relaxers □ Blood Pressure
□ Insulin □ Aspirin/Similar □ Other: _____

PAST HEALTH HISTORY

Major Surgery/Operations: □ Appendix □ Tonsils □ Gall Bladder □ Hernia □ Heart
□ Back □ Leg □ Other: _____
Major Accident or Falls: _____
_____
Hospitalization (Other Than Above): _____
_____
Previous Chiropractic Care: Doctor's Name and Date of Last Visit: _____
_____
Have You Been Treated For Any Health Condition In The Last Year: □ Yes □ No
If Yes, Please Explain: _____
Does Anyone Else In Your Family Have The Same Or Similar Conditions:_____