WELCOME TO OUR OFFICE

1

ABOUT YOU

Today's Date___/___/____

Name:_____

Preferred Name:_____ ☐ Female ☐ Male

Birth date __/__/____ Age_____ SS#_____

Home Address:_____

City:_____ ST:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Referred By:_____

Employer:_____ How Long?_____

Employer's Address:_____

City:_____ ST:_____ Zip:_____

Occupation:_____ Work Phone:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name_____

Medical Physician's Name_____

2

INSURANCE INFO

(If card is provided to office, this box doesn't need to be completed.)

Company Name: _____

Address: _____

Phone #: _____

Member #:_____

Group #: _____

Insured's Name: _____

Relationship: _____DOB__/__/____

Insured's Employer:_____

REASON FOR VISIT

Have you had previous chiropractic care?_____

What health condition has brought you here?_____

Other Conditions:_____

How did the condition develop:_____

Date of onset:_____Have you had the same condition in the past?_____

Is this condition getting worse?_____

How long has it been since you really felt good?_____

What aggravates the condition?_____Relieve it?_____

What percent of time does this condition bother you? ☐ 0 ☐ 25 ☐ 50 ☐ 75 ☐ 100

How would you rate the level of discomfort on a scale of 1-10 (0=no pain 10=extreme)? _____

3

(continued on back side)