CONFIDENTIAL PATIENT INFORMATION **DATE_____**

Email_____

Legal First Name_____ Last Name_____Phone_____

Address_____City/Zip_____

Age_____Sex_____Date of Birth_____Social Security #_____

Occupation_____Employer_____Phone_____

Marital Status _____ Spouse_____ Spouse's S.S. No._____

Spouse's Birthday_____ Spouse's Employer_____

Emergency Contact_____Relationship_____Phone_____

How were you referred to our office?_____Have you had previous chiropractic care? __ Y __N

Date of Injury or accident _____ Height _____ Weight _____ Do you wear a heal lift?

INSURANCE INFORMATION

Please check the following insurances you will be using in our office:

Automobile Insurance	Major Medical	Medicare
Workers' Compensation	NO INSURANCE	Other

Insurance Company_____Address_____
Policy #_____Group#_____Claim#_____
Insured's Name (if not your own)_____Insured's SS#_____
Relationship to Insured ____ Self ____ Spouse ____Child ____ Other
Do you have other insurance? ___Yes ___ No: Company_____ Policy #_____
Method of payment you plan to use for today's charges ____Check ____Cash ____ Mastercard ____ Visa

---

Please list all doctors seen for THIS PROBLEM:_____
Please list all previous accidents or injuries:_____
_____
Please list all past surgery:_____
Please list all medications you are taking:_____
Please describe your chief complaints:_____
When did it begin? _____ How did it begin? _____
Is this problem work related? ____Y _____N If yes, have you informed your employer? _____Y _____N
Have you had this problem before? Explain _____
What increases the pain? _____
What decreases that pain? _____