

Confidential Patient Information

Date: _____ Full Name: _____ Phone: _____

Name of Spouse or Guardian: _____

Street Address: _____ City/State/Zip: _____

Marital Status: Married Single Widow(er) Divorced Age: _____ DOB: _____

Pregnant? Yes No Unsure Number of Children: _____ Social Security #: _____

Height: _____ Weight: _____ Occupation: _____

Employer: _____ Employer Phone: _____

Name of Emergency Contact: _____ Phone: _____

Who may we thank for referring you to us? _____

Reason for appointment & related health problems	Date condition started, how long	Have you had before:	injury related:
1. _____	_____	yes / no	yes / no
2. _____	_____	yes / no	yes / no
3. _____	_____	yes / no	yes / no

Current Medications: _____

Previous Surgeries (please list all types and approximate date): _____

Medical Doctors consulted in the past year:

Name: _____ Approximate date of last visit: _____

Name: _____ Approximate date of last visit: _____

Chiropractic Doctors consulted in the past year:

Name: _____ Approximate date of last visit: _____

Name: _____ Approximate date of last visit: _____

Confidential Patient Information (cont.)

Please circle the following conditions you may have had in the past or have now:

Allergies	Diarrhea	Epilepsy	Headaches	Glaucoma
Alcoholism	Eczema	Kidney Disease	Stroke	Gout
Anemia	Gall Bladder Disease	Miscarriage	Ulcers	Roseola
Arthritis	Heart Attack	Multiple Sclerosis	Neck Pain	Fainting
Back Pain	High Blood Pressure	Venereal Disease	Polio	Scoliosis
Cancer	Heart Disease	Bladder Infections	Pleurisy	Flat Feet
Convulsions	Blood Vessel Disease	Nervousness	Mumps	Measles
Cold Sores	Low Blood Sugar	Uterine Cysts/Tumors	Rubella	Neuritis
Constipation	Menstrual Cramps	Tuberculosis	Chicken Pox	Depression
Diabetes	Irregular Periods	Pneumonia	Migraine	Other: _____
Sinus Trouble	Thyroid Problems	Whooping Cough	Malaria	_____

Payment Policies

- 1. PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF THE OFFICE VISIT.**
- 2. At the completion of your first office visit, you will be advised as to a time you may return for your second consultation when the Doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options and financial arrangements.**

Assignment and Release

I authorize the release of information to insurance companies.

I authorize the release of information to my employer.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes

I acknowledge that I am financially responsible for all services. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

