



## Confidential Patient Information

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status:  M  S  D  W  
Email Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Number of Children: \_\_\_\_\_  
Referred By (Doctor, Website, Friend, etc.): \_\_\_\_\_

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Have you received chiropractic care before?  Yes  No Date: \_\_\_\_\_  
Is this injury or illness related to an automobile accident?  Yes  No  
Date / Time: \_\_\_\_\_ Location: \_\_\_\_\_  
Auto Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Third Party Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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Due to changes in insurance reimbursement policies, payment is expected at the time services are rendered. Patients seeking reimbursement from their insurance provider will receive statements directly and are responsible for submitting claims independently.

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All charges are due when services are rendered.  
Method of Payment:  Check  Cash  Credit Card

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Chiropractic care may help relieve pain, improve mobility, and support long-term spinal health. Some patients seek temporary symptom relief, while others pursue corrective care focused on addressing underlying causes.

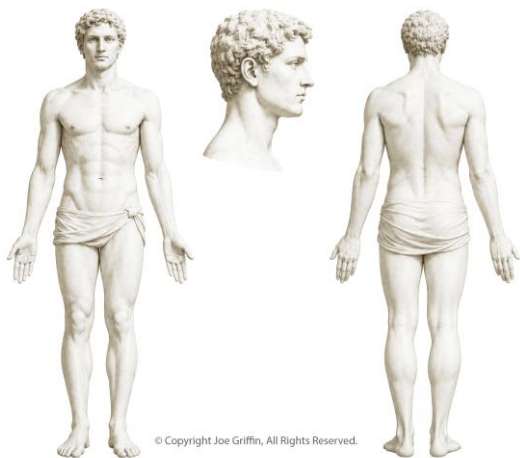
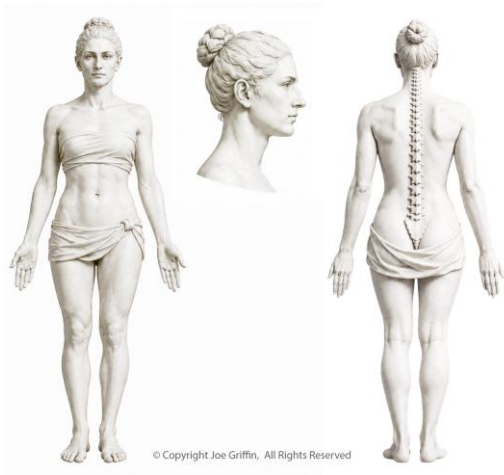
<b>RELIEF CARE</b> Relief care is intended to reduce pain and discomfort as efficiently as possible, though symptoms may return if the underlying issue is not corrected.	<b>CORRECTIVE CARE</b> Corrective care focuses on improving spinal function and addressing the underlying source of symptoms for more lasting improvement.
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I authorize this chiropractic office to render necessary care and understand that I am responsible for all charges incurred.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian: \_\_\_\_\_

Place an X to where your problems are



What is the reason for your visit?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If anything hurts, how long has it hurt?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

When did these problems originally started?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Check any of the following you have had in the six months:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Numbness
<input type="checkbox"/> Sinus Congestion / Allergies	<input type="checkbox"/> Frequent Nausea / Vomiting
<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Abdominal Cramps
<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Constipation
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Poor / Excessive Appetite
<input type="checkbox"/> Lung Problems / Congestion	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Blood Pressure Problems	<input type="checkbox"/> Painful / Excessive Urine
<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Discolored Urine
<input type="checkbox"/> Prostate / Sexual Dysfunction	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Menstrual Cycle Dysfunction	<input type="checkbox"/> Cancer

Are you pregnant?  Yes  No  Not Sure