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.): _____

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: _____

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.

All charges are due when services are rendered.

Method of Payment: ☐ Check ☐ Cash ☐ Credit Card

Why Chiropractic? 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.

RELIEF CARE	**CORRECTIVE CARE**
Relief care is intended to reduce pain and discomfort as efficiently as possible, though symptoms may return if the underlying issue is not corrected.	Corrective care focuses on improving spinal function and addressing the underlying source of symptoms for more lasting improvement.

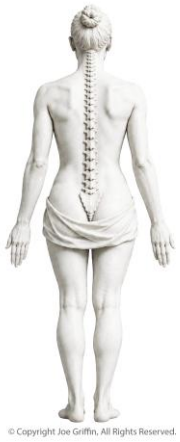
I authorize this chiropractic office to render necessary care and understand that I am responsible for all charges incurred.

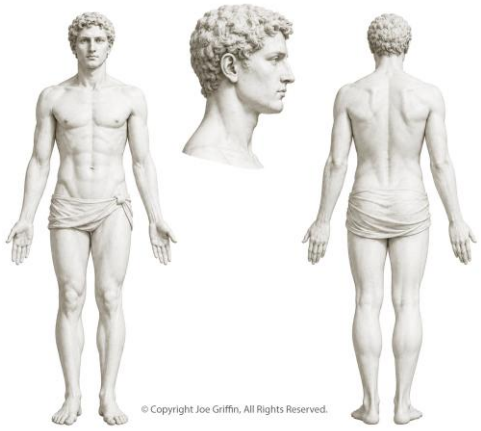
Patient Signature: _____ Date: _____

Parent or Legal Guardian: _____

UPPER CERVICAL CHIROPRACTIC OF ARIZONA

Use an X to mark 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:

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

Are you pregnant? ☐ Yes ☐ No ☐ Not Sure