



Welcome to our Practice!

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ **Preferred Name:** _____

Birthdate: ____/____/____ **Age:** _____ **Gender:** Male Female

Social Security Number: _____ (for insurance purposes)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email Address:** _____

Occupation: _____ **Employer:** _____

Marital Status: Single Married Partner Divorced Widowed

Spouse/Partner's Name: _____

Children's Names & Ages: _____

Referred By: _____

INSURANCE INFORMATION

(If patient is primary insured you may skip this section)

Primary Insured Name: _____

Primary Insured Birthdate: ____/____/____ **Social Security Number:** _____

Employer: _____ **Relation to Self:** _____

Insurance Company Name: _____

Please continue on back.

REASON FOR TODAY'S VISIT

Is this an auto injury? Yes No

Is this a work related injury? Yes No

Is this condition getting worse? Yes No Constant Comes & Goes

Is this condition interfering with your: Work Activities Sleep Daily Life

Have you had a similar condition in the past? Yes No If Yes, please explain:

Have you been treated by a Medical Physician, Chiropractor or any other health care professionals for this condition?

If so, please list the providers you have seen:

PATIENT HISTORY

Please list any family history of spinal problems or other health concerns:

Please list any serious illnesses and/or operations you have had, with dates:

Do you routinely go for:

Spinal Check-ups? Yes No

Physicals? Yes No

Dental Check-ups? Yes No

Exams? Yes No

How often do you exercise?: _____

What are your favorite forms of exercise?: _____
