



Patient Introduction
Please answer ALL questions

1. NAME: _____ 2. PHONE: _____

3a. ADDRESS: (include city, state and zip) _____

3 b. E-MAIL ADDRESS: _____

4. DATE of BIRTH: _____ 5. AGE: _____ 6. NO. of CHILDREN: _____ 7. OCCUPATION: _____

8. () MALE () FEMALE 9. () SINGLE () MARRIED () DIVORCED () WIDOW

10. SPOUSE'S NAME: _____

11. NAMES AND AGES OF CHILDREN: _____

12. SS# _____ 13. EMPLOYERS' NAME: _____

14. WORK ADDRESS: _____ 15. WORK PHONE: _____

16. REFERRED BY: _____ 17. DO YOU HAVE INSURANCE?: Yes No

18. HAVE YOU HAD CHIROPRACTIC CARE BEFORE?: Yes No

19. IF SO, WHERE: _____

20. WHAT IS YOUR REASON FOR CONSULTING THIS OFFICE? _____

21. ARE YOU HERE BECAUSE OF: () AUTO ACCIDENT () JOB INJURY () OTHER

22. DATE OF INJURY: _____ 23. ATTORNEY: _____

24. NAME OF INSURANCE COMPANY: _____ 25. CLAIM NO: _____

(please furnrsh front desk with your insurance card)

26. MEDICARE: Yes No POLICY # _____

27. MEDICAID: Yes No POLICY # _____

28. HAVE YOU HAD ANY FALLS, INJURIES OR AUTO ACCIDENTS? Yes No

IF YES, PLEASE DESCRIBE: _____

29. HAVE YOU EVER HAD SURGERY? Yes No

IF YES, PLEASE DESCRIBE: _____

30. ARE YOU PRESENTLY TAKING ANY MEDICATIONS? Yes No

IF YES, PLEASE LIST: _____
