CONFIDENTIAL PATIENT REPORT

(PLEASE PRINT)

Name________________________Address____

City, State, Zip _________________________Home Phone________________Cell ___________

SS#________________ Birth Date ____________Age _______ Sex: M F Ht .______Wt._____

# of Children ______ M S D W Spouse's Name (or parent) _____________________________

Occupation______________________ Employed by: ______________Work Phone___________

Email Address____

How were you referred to our office? Friend's name ________________Other: _____________

Have you ever had Chiropractic Care before? _______If yes, when? ______________________

List your chief complaints in order of severity:

1. ____ For how long? _____________
2. ____ For how long? _____________
3. ____ For how long? _____________

List Doctors consulted for this condition:

1. _______________________ Address:____
2. _______________________ Address: ____

Is this injury or illness work-related? ____ If yes, have you reported it to your employer? ______
Is this injury or illness related to an accident? ______If yes, please fill out the following:
Auto Ins Co. _______________________Policy # ____________Claim # ___________________

Do you have health ins.?_____Company?_____________________Address_________________

Policy number__________________________ Insured Birth Date______________

Do you have a medical reimbursement account with your employer?_____________________

Do you have a medical Pre-Tax reimbursement account with your employer?_____________

Are you covered under any other group or individual health policy through yourself or a spouse?
If yes, Ins. Co. name and address _______________________ Policy #________________
Group # ____________ Spouses SS#______________ Ins Co. name and address___________

ID # _________________ Group # ______________

Notice: Not all patients require x-rays to determine or verify a diagnosis, type of treatment and length of treatment. If your examination warrants x-ray analysis, the following office policy prevails:

1. **All first visit charges are payable when services are rendered.**
2. **The fee paid for treatment of x-rays is for analysis only. The film itself is the property of this office.** ***If there is a possibility of pregnancy please inform the Dr.***

Patient's Signature: ____________________________________ Date ____________

Are you here for a FREE Spinal Exam only? ____yes _____no