Today's Date: _____

Patient Introduction

Your Name: _____
First Middle Last Called Name?

Street Address: _____

City _____ State _____ Zip _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Sex M F Marital Status: S M W D

Birth Date: _____ Age: _____ Social Security #: _____

How Did You Hear About Us?: _____

Employer: _____ Occupation: _____

Employer Address: _____

City _____ State _____ Zip _____

Name of Spouse or Guardian(s): _____

Their Date of Birth: _____ Their SSN: _____

Their Contact #: _____ Alternate #: _____

Their Employer: _____ Their Occupation: _____

Employer Address: _____

City _____ State _____ Zip _____

Emergency Contact: _____ Phone: _____

Previous Chiropractor: _____ Last Visit: _____

Reason for leaving: _____

Present MD: _____ City: _____

Is your condition due to an accident? Yes No Date of accident? _____

Type of accident? Auto Work/On Job At Home Other: _____

Have you ever been in an auto accident? Past Year Past 5 Years >5 Years Never

Do you have Insurance? Yes No Do you have Medicare? Yes No

If you have insurance and would like for us to check your benefits or leave it on file please bring it to the receptionist with your Drivers License. Thank you.