Family Chiropractic Case History/Patient Information

Name:	Email Address					
Address:						
		Social Security #				
Age: Birth Date:	Race:	Marital:	MSWD	How many chil	dren?	
Occupation:	Empl	oyer:				
Employer's Address:			_ WorkPhor	ne:		
Spouse:	Occupation:		Employe	r:		
Name of Emergency Contact :			Pho	one:		
How were you referred to our off	ice?					
Your Medical Doctor:						
May we have your permission to	update your med	dical doctor r	egarding you	r care at this office	?	
Chief Complaint: Purpose of this	appointment:			2		
Date symptoms appeared or acc	ident happened:					
Is this due to: Auto Work	Other					
Have you ever had the same or a	a similar condition	n? Yes	No			
describe:						
Days lost from work:				1:		
Have you had any major illnesse Have you been treated for any h				2	-	
If yes, describe:	•					
What medications or drugs are y						
Triat medications of drage are y	ou taking					
AUTHORIZATION AND RELEATION Chiropractic office. I authorize physicians and other healthcare responsible for all costs of chiro or terminate my schedule of calimmediately due and payable. The patient understands and a for the purpose of treatment, know how your Patient Health those records. If you would like the privacy of your Patient available to you at the front deyour medical records, please in	the doctor to re providers and pa practic care, regare as determined agrees to allow a payment, health information is to have a mor Health Informatesk before signing	elease all in- lyors and to searchess of instance of the search of the search of the search of the detailed a search of this consumer of this	ormation nescure the passurance cover ing doctor, a actic office to tions, and contract in the count of ourage you	cessary to commyment of benefits. rage. I also under ny fees for profes o use their Patie coordination of chis office and your policies and profes to read the HI	nunicate with personal I understand that I am retand that if I suspend ssional services will be nt Health Information care. We want you to our rights concerning paa NOTICE that is	
Patient's Signature:				Da	te:	
Guardian's Signature Authorizing				Dai		

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Have you had any major illned Have you been treated for an							
If yes, describe:					3		
What medications or drugs a							
vinat medications of drugs a	re you taking!						
					9		
AUTHORIZATION AND RE chiropractic office. I author physicians and other healthdresponsible for all costs of cor terminate my schedule of immediately due and payable	ize the doctor to re are providers and pa hiropractic care, rega f care as determined	elease all in ayors and to ardless of in	formation ne secure the pa surance cove	ecessary to commayment of benefits erage. I also unde	nunicate with personal s. I understand that I am erstand that if I suspend		
The patient understands a for the purpose of treatme know how your Patient He those records. If you would the privacy of your Patie available to you at the from your medical records, please	ent, payment, healt ealth Information is d like to have a mor ent Health Informat t desk before signi	hcare opera s going to be the detailed a tion we end ng this cons	ations, and one used in the count of or courage you	coordination of his office and your policies and p I to read the H	care. We want you to our rights concerning rocedures concerning IPAA NOTICE that is		
Patient's Signature:				Da	ate:		
Guardian's Signature Author					ate:		