

**CHIROPRACTIC ASSOCIATES  
CONFIDENTIAL PATIENT INFORMATION:**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

AGE \_\_\_\_\_ DOB \_\_\_\_\_ SS \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ MARITAL STATUS M S W D

PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_

E-MAIL \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_

INSURANCE COMPANY INFORMATION IN FILE \_\_\_\_\_ COPY OF CARD \_\_\_\_\_

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**CHIEF COMPLAINT** \_\_\_\_\_

**HOW LONG HAS THIS EPISODE AFFECTED YOU?** \_\_\_\_\_

**COMPLAINTS OTHER THAN CHIEF COMPLAINT** \_\_\_\_\_

HAVE YOU HAD PREVIOUS EPISODES? \_\_\_\_\_ WHEN \_\_\_\_\_

IS THIS DUE TO: AN INJURY \_\_\_\_\_ ON THE JOB \_\_\_\_\_ AUTO \_\_\_\_\_

HAVE YOU LOST ANY DAYS OF WORK? \_\_\_\_\_ WHEN \_\_\_\_\_

OTHER DOCTORS SEEN FOR THIS CONDITION? \_\_\_\_\_

WHAT DO YOU BELIEVE IS WRONG WITH YOU? \_\_\_\_\_

HAVE YOU RECEIVED CHIROPRACTIC CARE PREVIOUSLY? \_\_\_\_\_

WHAT MEDICATIONS DO YOU CURRENTLY TAKE \_\_\_\_\_

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PLEASE LIST ALL PAST FRACTURES, SURGERIES, OR INJURIES: \_\_\_\_\_

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IS THERE ANY OTHER MEDICAL CONDITION YOU THINK WE SHOULD KNOW ABOUT? \_\_\_\_\_

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**WHO MAY WE THANK FOR YOUR REFERRAL?** \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**INFORMATION**

**TAKEN BY** \_\_\_\_\_ **DATE** \_\_\_\_\_