CONFIDENTIAL HEALTH INFORMATION

This information is needed in order to provide you with the most appropriate health care services.
Please fill in all portions of this form for complete health related information.
Need assistance-ask Alicia or Dena for help.

Name: ______________________ Date: ______________
Address ______________________________
City: ______________ State: ________ Zip: ______________
Home Phone: __________ Cell Phone: __________ Work Phone: ______________
Email: ______________________________
Age: _____ Date of Birth: __________ SS#: __________ Dr.Lic.#: ______________
Marital Status: Single: ________ Married: _______ # Children: ______________
Occupation: ______________ Employed By: ______________
Spouse's Name: ______________________________
Spouse's Employer ______________ Work Phone: ______________
Name of Person to contact in an Emergency: ______________ #: __________

Please provide us with the health related services and/or names of health care providers:
Name of your MD or DO: ______________________________
Name of other physicians that provide you care: ______________________________
____
Do you receive massage therapy? ___ acupuncture? ___ PT ___ Other ______________
Have you received chiropractic care in the past? Yes ___ No ___ Name: ______________
Pregnant? ______ Due Date: __________ #Children: ______ (circle): Natural/C-section ________
List of Medication: ______________________________
____
List of vitamins/herbs: ______________________________
List accidents, trauma, or surgeries and their dates: ______________________________
____
____
____
Are you here for (check one): wellness care ___ spinal or extremity injury ___ work injury ____
auto accident ____ sports injury ______ other: ______________________________
What exercise do you do? ______________________________
Do you drink water? ________ Do you drink alcohol? ______ Smoke? ____ How Much? ________
Do you drink soda? _______ Tea? _____ Coffee? ________ How much of each? ______________
Do you have any disabilities? ______________________________
Do you have high stress? _____ (check mark): home ______ work ______ relationship ___________

I have answered the above information to the best of my ability. I understand that chiropractic services are best delivered when all health related information is given to the Doctor. I further understand that any charges incurred while under the Doctor's care is my responsibility within the guidelines of your health insurance plan, auto insurance plan, or legal settlement. Financial plans available upon request.

Patients signature: ______________________________ **Date:** ______________
Parent or Guardian: ______________________________ **Date:** ______________

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