# WELCOME TO
# SCHROEDER FAMILY CHIROPRACTIC

We are pleased to welcome you to our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your health.

## Patient Information

Name_____SS#_____
Address_____DL#_____
City_____St.___Zip_____Phone_____Cell_____
Sex □ M□ F Age_____Birth Date___/___/____ Height_____ Weight_____ Status M S W D
Employed By_____Occupation_____
Business Address_____Phone_____
Spouse's name_____Occupation_____Employer_____
Whom may I thank for referring you?_____
Notify in case of emergency_____Home Phone_____Cell_____

## Primary Insurance

Insurance Company_____ Phone_____
ID#_____Group #_____
Person responsible for account_____
Relation to patient_____Birth Date_____SS#_____
Address if different than patients_____City_____
St._____ Zip _____ Phone _____Cell_____
Person responsible employed by_____Occupation_____
Business Address_____Phone_____

## Reason for Visit

Have you ever seen a Chiropractor?_____ If yes when and why?_____
Your reason for this visit_____
Please describe your pain and location_____
When did symptoms begin, lately?_____Have you had similar conditions in the past?_____ Is pain getting □ Worse □ Better □ Same □ Comes & goes How often?_____
Have been helped by a medical physician for this condition?_____ Are you taking any medications? _____ What kind?_____For what condition & Dates_____
_____ List vitamins if taking any_____
List surgical operations & Dates_____ List fractures & Dates_____

I clearly understand and agree that all services rendered to me are changes directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature_____Date_____