Welcome! 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____
SSN__________________________ DL#______________________________
Address_________________________ City______________St.____Zip__________
Phone_____________ Cell_____________ Email Address__________________
Height_____ Weight_____ Sex M / F Status M / S / W / D Age_______ Birth Date___/___/______
Employed By______________________________ Occupation_________________
Business Address____________________________________Phone___________
Spouse's name________________Occupation______________Employer__________
Emergency Contact____________________ Home Phone__________Cell__________
Whom may I thank for referring you?_________________________________
Have you ever seen a Chiropractor?_____If yes when and why?____________________

Primary Insurance

(Omit if not going through insurance or if providing an insurance card)

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

What brings you in today?____
Describe your symptoms & location______________________________________
When did symptoms begin, lately?______________Is this a recurring condition?___________
Is pain getting ☐Worse ☐Better ☐Same How often?___________________ ☐Comes & goes
Have seen 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_______________