Health History

Name: _____ Address: _____

City: _____ State: ____ Zip: _____ Home: ( ) _____ Cell: ( ) _____

Email: _____ SSN: _____ Date of Birth: ___/___/___ Age: _____

Height: _____ Weight: _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced No. of children: _____

Name of Spouse (or parent): _____ How were you referred to our office? _____

(*Females only*) Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Employer: _____ Address: _____

City: _____ State: ____ Zip: _____

Work: ( ) _____ Occupation: _____

Have you ever had Chiropractic care before? Yes / No If yes, when? _____

If you are experiencing any health problems, please list your chief complaints in order of severity

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

List other doctors consulted for these conditions:

1. _____ 2. _____

Family Physician's Name: _____ Phone: ( ) _____

Address: _____

Do you ever experience any of these complaints while working? _____

If yes, describe the activities that may be causing you to experience these complaints:_____

_____

Are there other activities, incidents, or events outside of work that may have caused these complaints? _____

If Yes, explain: _____

_____

If this is due to an injury or accident, what is the date of injury? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

_____

Indicate medications (over the counter/prescriptions) you are currently taking: ☐ Aspirin/Tylenol

☐ Pain killers ☐ Muscle Relaxants ☐ Insulin ☐ Tranquilizers ☐ Birth Control Pills ☐ Others:

_____

Have you been involved in an auto accident in the last 12 months? _____ If yes, when? _____

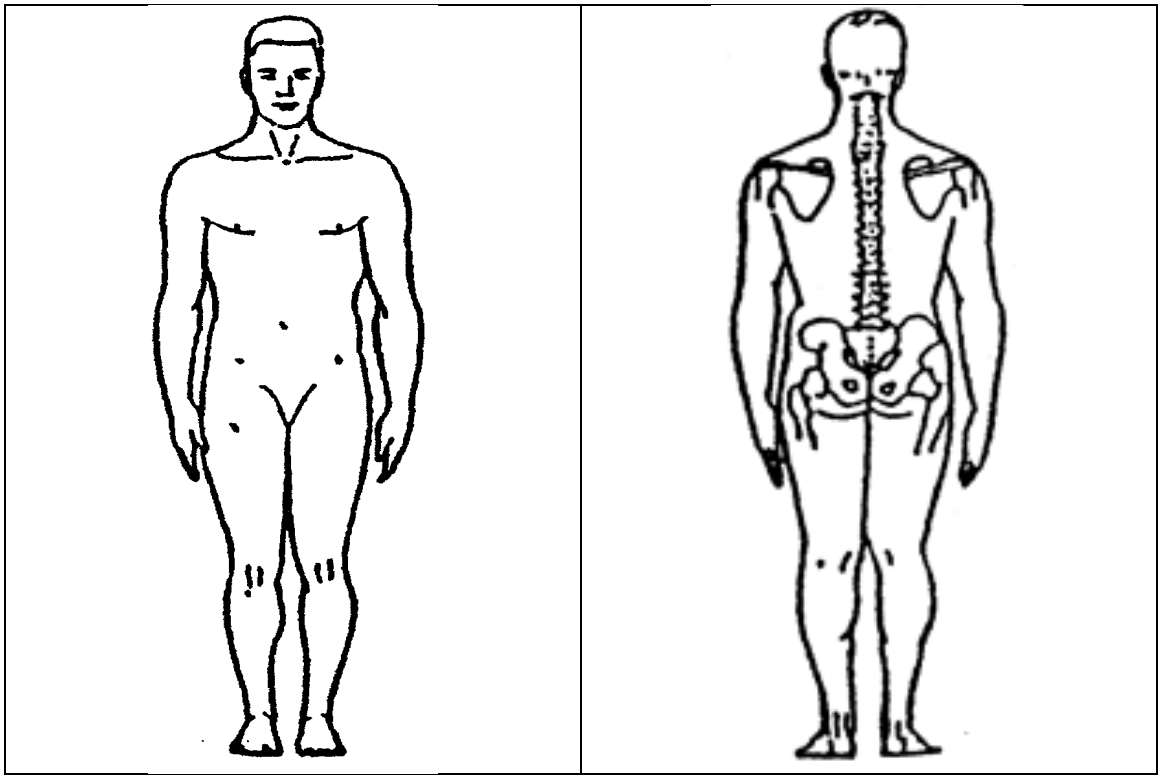
Health History

For your convenience, a complimentary insurance verification may be provided.

Simply provide us with a copy of your insurance card, and we'll verify your benefits.

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below.

COMPLETE THESE DIAGRAMS



NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE.

IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature _____ Date _____