

Life BALANCE CHIROPRACTIC

Confidential Patient History

Name _____ Referred by _____ Date _____
Address _____ City/State/Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Email Home _____
Email Work _____ SS# _____ Birth Date _____ Age _____ Sex SM SF Height _____ Weight _____
Drivers License # _____ Marital Status SS SM FD SW Number of Children _____
Occupation _____ Employed by _____
Work Address _____ City/State/Zip _____
Spouses Name _____ SS# _____ Employer _____

Have you had chiropractic care before? Yes No If yes, Doctor's name and date of care; _____

List your complaints in order of severity:

1. _____ How often _____ When did the most recent episode start? _____
2. _____ How often _____ When did the most recent episode start? _____
3. _____ How often _____ When did the most recent episode start? _____

Have these problems been getting worse or staying the same? _____

Currently or in the past, have you ever experienced any of these complaints while working? If yes, please describe which activities or positions at work may be causing you to experience these complaints; _____

Are there any activities incidences, or events outside of work that may have caused these complaints? If yes, please explain; _____

Have you at any time in the past suffered a work injury? No Yes, if Yes, what is the date of injury? _____

Have you been involved in an auto accident in the last 12 months? No Yes, if Yes, what is the date and details of the accident? _____
If so, what care have you received for your injuries? _____

Please list any injury or illness that you are currently being treated for that is not listed above; _____

Have you ever had any surgeries or been hospitalized? N Y, if yes please explain _____

Drugs you now take: Aspirin/Tylenol Painkillers Insulin Antacids Birth Control Pills Are you pregnant? N Y

Other over the counter or prescription drugs you now take _____

How do you want to handle your problem? Temporary Relief Maximum Correction What is your health philosophy? _____

Do you have any type of insurance? Yes No Health Insurance Company _____ Are you covered under any other group or individual health policy through yourself or your spouse? Y N If yes, please list insurance company's name and insured SS# _____

Method of payment for today's charges. Cash Check VISA/MC

I understand that all first visit charges are payable when service is rendered. I also understand that unless other agreements have been made, I am financially responsible for all services rendered to me including those that are not covered by my insurance company.

Patients Signature _____ Date _____