



# Patient History (Confidential)

Date: \_\_\_\_\_

## PATIENT INFORMATION:

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent(s) Name (if patient is a minor): \_\_\_\_\_

Tel: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cel: \_\_\_\_\_ Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Other: \_\_\_\_\_

Sex:  Male  Female Marital Status:  M  S  W  D No. Children: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred By: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Driver Lic.#: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Yrs. employed: \_\_\_\_\_

Employer's address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## EMERGENCY CONTACT:

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phones: Day: \_\_\_\_\_ Eves: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Relationship: \_\_\_\_\_ Occupation: \_\_\_\_\_

Main concern(s) you would like to address: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes  Other \_\_\_\_\_

Is this condition interfering with your:  Work  Sleep  Daily routine  Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Surgeries: \_\_\_\_\_

Accidents and/or significant trauma (including emotional): \_\_\_\_\_

Illness(es): \_\_\_\_\_

Current Medications: \_\_\_\_\_

Any nonprescription drugs?  Yes  No What kind? \_\_\_\_\_

**OTHER DOCTOR SEEN FOR THIS CONDITION:**  None  MD  DC  DO  DDS  Other \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Telephone: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Please check all tests you have had:  X-rays  Urinalysis  Blood Test  Other: \_\_\_\_\_

What treatments:  Pills  Shots  Traction  Physiotherapy  Other \_\_\_\_\_

Length of time under his care: \_\_\_\_\_ Results: \_\_\_\_\_

Were you off work?  Yes  No For how long? \_\_\_\_\_ Have you returned to your same job?  Yes  No

If not, why? \_\_\_\_\_

I give my permission for chiropractic treatments and/or BodyTalk sessions to be rendered. I understand the nature of those treatments. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of service.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

See the back page >>>

