

## Patient Information

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ SSN: \_\_\_\_\_  Male  Female

Single  Married  Divorced Name of Spouse (or parent): \_\_\_\_\_ No. of children: \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

(Females only) Are you pregnant?  Yes  No  Unsure

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Have you ever received 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. \_\_\_\_\_ For how long? \_\_\_\_\_

2. \_\_\_\_\_ For how long? \_\_\_\_\_

3. \_\_\_\_\_ For how long? \_\_\_\_\_

List other doctors consulted for these conditions:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Family Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you been involved in an auto accident in the past 12 months?  Yes  No If yes, when? \_\_\_\_\_

Are these complaints the result of a work-related injury?  Yes  No If yes, when? \_\_\_\_\_

Are these complaints related to an event outside of work?  Yes  No If yes, when? \_\_\_\_\_

Have you ever had any surgeries or hospitalizations?  Yes  No If yes, please list: \_\_\_\_\_

Indicate any current medications (include over the counter or prescription):  Aspirin/Tylenol

Pain killers  Muscle Relaxants  Anti-Depressants  Other: \_\_\_\_\_

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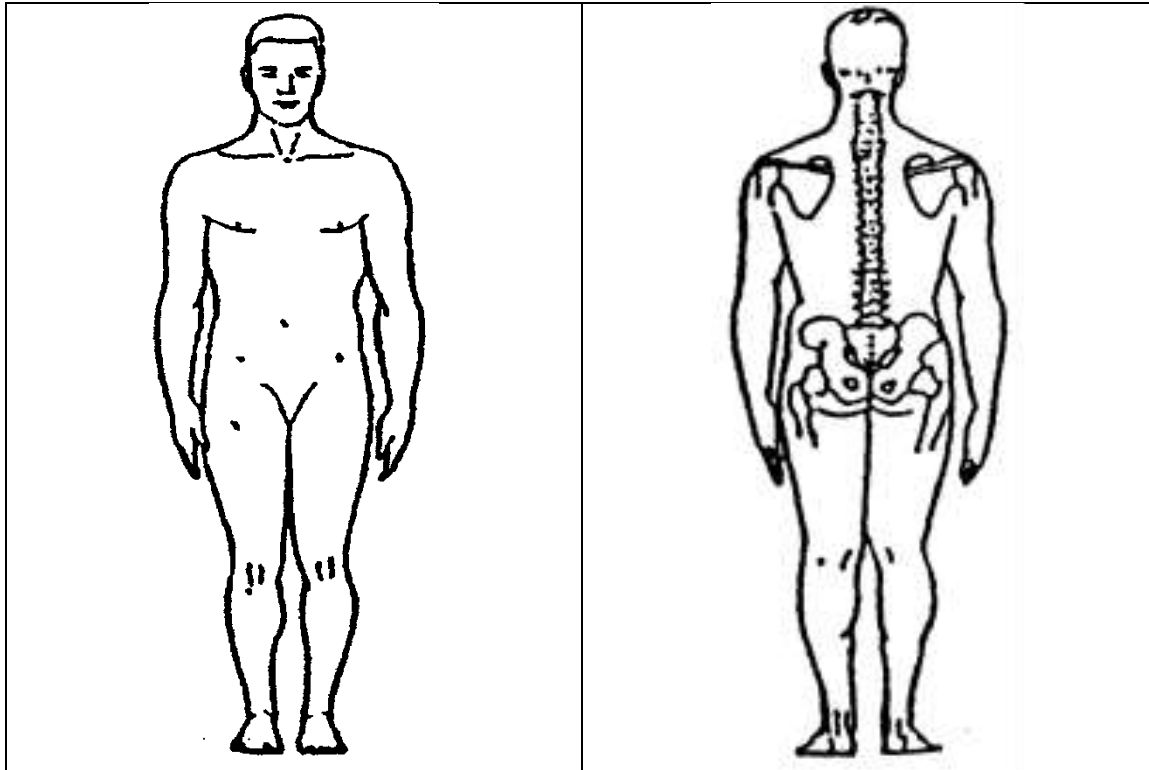
**For your convenience, a complimentary insurance verification may be provided.  
Simply provide us with a copy of your insurance card, and we'll verify your benefits.**

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

### COMPLETE THESE DIAGRAMS



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 \_\_\_\_\_