Personal History

Name: ______ Birth Date: ______ Age: ______ ☐ Male ☐ Female

Address: ______ City: ______ State: ______ Zip: ______

Home# ______ Work# ______ Cell # ______

Social Security # ______ Drivers Licence # ______

Employer: ______ Type of Work: ______

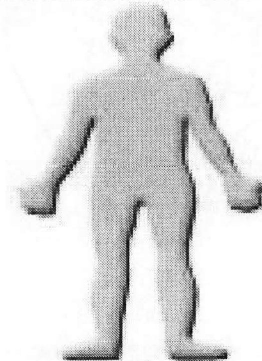
Circle One: Married Single Divorced Widowed Seperated Number of Children ______

Spouses Name: ______ Contact # ______

Emergency Contact Name & Number: ______

Who is responsible for your bill?

- ☐ Myself-No Insurance
- ☐ Myself and my Personal Insurance
- ☐ Auto Insurance
- ☐ Workers Comp Insurance
- ☐ Third Party Insurance



What is your condition? ______ Mark where you feel your pain.

Have you seen another Doctor for this condition? ______
(Their Name/s)

Types of treatment: ______

Results from these treatments: ______

When did this condition begin? ______ Has it occurred before? ______

Is this condition: Job Related Auto Accident Home Injury Fall Sports N/A

Please list all medications you currently use: ______

Do you wear a shoe lift: Yes No

Do you suffer from any condition other than which you are consulting us? ______

Past Health History:

Major Surgery/Operations: ______

Broken Bones: ______

Hospitalizations: ______

Major Accidents and Falls: ______

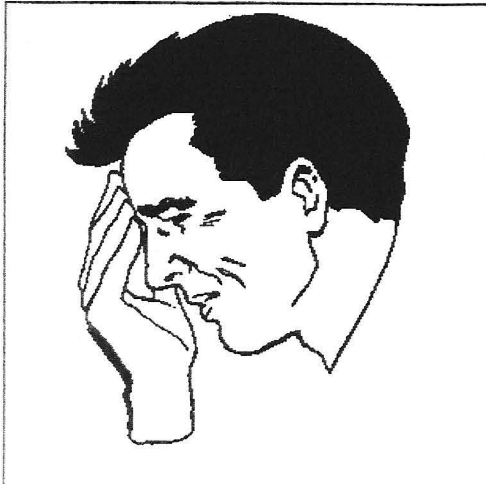
Circle: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery

Previous Chiropractic Care: (Date/Doctor) ______

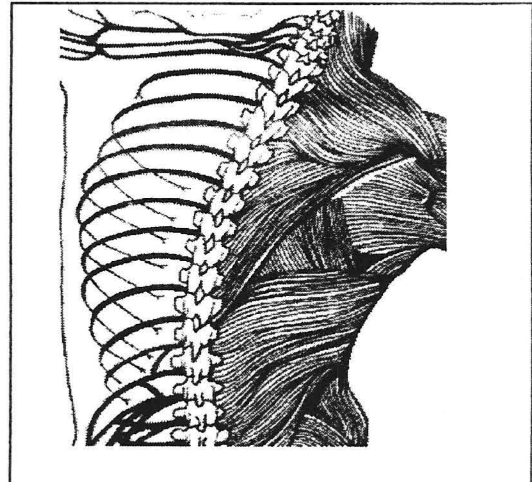
Why chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of their pain or dicomfort (Refief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending a treatment program for you.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care** ☐ **Corrective Care** ☐ **The Doctor may decide the appropriate care for my condition**



Refief Care: Relief care is necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that is getting wet from a leak but not fixing the leak.



Corrective Care: The goal for corrective care is, while relieving the symptoms, to correct the cause of the problem. This varies in it's length of treatment time, but is longer lasting.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on reciept. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediatley due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for the examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature: ______________________ **Date:** ____________

Guardian/Spouses Signature authorizing care: ______________________