PERSONAL HEALTH HISTORY

(Please print clearly, completing all the blanks you can.)

Name:_____ Address:_____ City:_____
(FIRST) (MI) (LAST)

State:_____ Zip:_____ Home Phone:_____ Work Phone:_____ Cell:_____

e-mail address:_____ Sex:_____ Birthdate:_____ Today's Date:_____

Height:_____ Weight:_____ Social Security #:_____ Driver's License #:_____

Name of Employer:_____ Type of Work:_____

Your spouse's name and employer: _____

Your marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Who is responsible for the bill? ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Medicare

How will payment be made? ☐ Cash ☐ Check ☐ Insurance ☐ Worker's Compensation ☐ Auto Insurance policy

In case of emergency contact: _____ Phone:_____

How were you referred to our office?_____

Please describe your major problems below and mark their exact location on the diagram.
In addition, if these are a result of a motor vehicle crash or a work injury, please complete the last page.

_____

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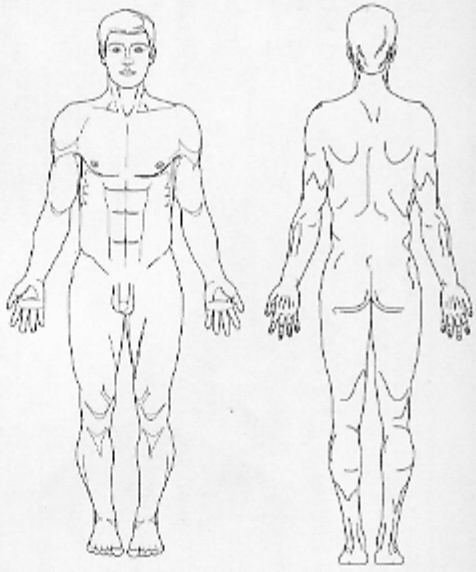

When did you first start having these symptoms? _____

What may have caused these symptoms? (example: fall, accident, lifting) _____

Has this problem been ☐ Getting Worse ☐ Getting Better ☐ Staying the Same?

Is there anything, that you do, that makes your condition worse? _____

Is there anything, that you do, that makes your condition better? _____

Have you ever had these symptoms before? ☐ Yes ☐ No If yes, please explain:_____

Have you had Chiropractic care in the past? ☐ Yes ☐ No Name: _____ Date:_____

Please describe what, if anything, has been done for your condition:_____

DO YOU HAVE A PACEMAKER? ☐ ***YES*** ☐ ***NO*** ***ARE YOU PREGNANT?*** ☐ ***YES*** ☐ ***NO*** ***DUE DATE:***_____

07/10