# CONFIDENTIAL PATIENT INFORMATION
## (Please Print)

Date: _____

Full Name: _____

Name of Wife, Husband or Guardian: _____

Address: _____
Residence and Mailing City State Zip Code

Marital Status: M S W D Age _____ Birth date _____ No. of Children _____

Pregnant? _____ Telephone Number ( ) _____ Social Security No. _____

Height: _____ Weight:_____Occupation: _____

Employer's Name/Address/Phone: _____

Spouse's Occupation/Employer: _____

Name and Address of Emergency Contact: _____
(Not living with you)

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

List Chiropractors you have seen before:

1. Name _____ Address: _____

When? _____ What did he say was wrong? _____

List Medical Doctors consulted within the past year:

1. Name _____ Address: _____

When? _____ What did he say was wrong? _____

2. Name:_____ Address:_____

When? _____ What did he say was wrong? _____

Family Doctor or Doctor to who you would like for us to send a report about your treatment in our office:
Name: _____ Address: _____

Date of last physical examination _____ Doctor who did exam _____

| List your problems or complaints according to their significance in your life. | Date started, or for how long | If you've had the condition before, when? | Did problem begin with an injury? |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

Name of person responsible for payment: _____

Do you have insurance that covers Chiropractic care? Yes _____ No _____

Name of Insurance Company: _____ Policy No. _____

Please list all medications you are taking: _____

_____

Surgery: (Please include all surgery)

1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

3. Type _____ When _____ Doctor _____

4. Type _____ When _____ Doctor _____

If additional space is needed please continue on another sheet

Accidents and/or injuries: (Especially those related to your present problems).

1. Type _____ When _____ Hospitalized Yes No

2. Type _____ When _____ Hospitalized Yes No

3. Type _____ When _____ Hospitalized Yes No

NOTE: If you have RECENTLY been involved in an accident or injury, please request and fill out our accident report form, which may be obtained from the FRONT DESK.

Check the following conditions you may have had or do have now:

| | | | |
|---|---|---|---|
| _____ Allergy | _____ Diarrhea | _____ Measles | _____ Rheumatic Fever |
| _____ Alcoholism | _____ Eczema | _____ Miscarriage | _____ Stroke |
| _____ Anemia | _____ Emphysema | _____ Multiple Sclerosis | _____ Heart Attack |
| _____ Arteriosclerosis | _____ Gall Bladder | _____ Mumps | _____ Tuberculosis |
| _____ Arthritis | _____ Gout | _____ Neuritis | _____ Thyroid Problems |
| _____ Backaches | _____ High Blood Pressure | _____ Nervousness | _____ Ulcers |
| _____ Cancer | _____ Heart Disease | _____ Depression | _____ Venereal Disease |
| _____ Convulsions | _____ Malaria | _____ Pleurisy | _____ Whooping Cough |
| _____ Constipation | _____ Menstrual Cramps | _____ Pneumonia | _____ Low Blood Sugar |
| _____ Cold sores | _____ Irregular Periods | _____ Polio | _____ Neck Pain |
| _____ Diabetes | _____ Migraine | _____ Headaches | _____ Back Pain |
| _____ Sinus | _____ Epilepsy | _____ Ringing in ears | |

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

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Information taken by _____ Date _____

Email Address _____

Would you like to receive a free Email newsletter? Y / N