

Patient Health Record

PATIENT INFORMATION

Name _____ State _____ Pager _____ r _____ Zip _____
Address _____ of Children _____
Home Phone(_____
Mailing _____
Address _____ Date _____
of Birth _____) S (if different from _____ City _____ Cell Phone _____ Sex: Male _____
Marital _____ above) M / S / D _____ Female _____ Number _____ Social Security _____
Status _____ / W / _____ Number _____
Driver's _____
License _____
Number _____

Age _____
SEP _____

Employer _____ Employer's Address _____ Work _____
Type of Work _____ Phone _____
Number _____

SPOUSE'S INFORMATION

Name _____ Type of Work _____ Employer _____
Work Phone _____ Number _____

MEDICATIONS

Are you currently taking any of the following medications?

Aspirin Pain Killers Muscle Relaxers Blood Pressure Medications Tylenol Nerve Pills Anti

Depressants Anti-Inflammatories Insulin Stimulants Blood Thinners Tranquilizers Other

HEALTH HABITS

Do you smoke? YES NO packs/day

Do you drink? YES NO drinks/day

Do you drink coffee? YES NO cups/day

Do you exercise regularly? NO Moderate Daily
 Do you wear? Heel Lifts Sole Lifts Inner Soles Arch Supports

HEALTH CONDITIONS

Severe or Frequent Headaches Sinus Problems	Digestive Problems Ulcers/Colitis	Venereal Disease HIV/Aids	Chemotherapy Anemia
Dizziness Loss of Sleep		Diabetes Tuberculosis	
	Heart Attack/ Stroke Congenital Heart Defect		Rheumatic Fever Psychiatric Problems
Pain Between Shoulders Numbness or Pain Arms/Hands/Legs/Back Problems	Heart Surgery/ Pacemaker Heart Murmur High/ Low Blood Pressure	Shingles Kidney Problems Hepatitis	Thyroid Problems Gout Other
Surgery If Yes, please explain type & date.	Difficulty Breathing	Arthritis	Cancer

HEALTH CONDITIONS (WOMEN ONLY)

Are you pregnant? Are you nursing? Do you experience painful periods? Do you have regular cycles? Do you have breast implants?	YES YES YES YES YES	NO NO NO NO NO
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INSURANCE INFORMATION

Company Insured's Name Relationship of Insured	Address policy Number Date of Birth	Phone Group Number Social Security #
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****As a courtesy to our patients, we verify eligibility & benefits as well as claims submissions. Please know that it is not a guarantee of payment. You may be responsible for all or a portion of services rendered to you. It is always a good idea to refer to your policy should you have any questions.*

Whom May We Thank For Referring You To Our Office?

EMERGENCY CONTACTS

Name	Name
Relationship	Relationship
Home Phone	Home Phone
Work Phone	Work Phone

AUTHORIZATION FOR CARE

I hereby authorize the doctor to work with my condition, through the use of chiropractic as he/she deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for services rendered to me will be **due immediately** and payable to *Community Chiropractic*. I understand that if I fail to pay any portion of my charges that my account will accrue at 18% interest until the balance is paid.

Patient's Signature Date _____

Minors Parent or Guardian Signature Date _____
