CONFIDENTIAL PATIENT INFORMATION

Davis Chiropractic

Date: _____

Full Name: _____email:_____

Name of Wife, Husband, or Guardian:_____

Address: (Street) _____ (City) _____ (Zip) _____

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

Pregnant?_____ Telephone: ( )_____ Cell _____

Height:_____ Weight:_____ Occupation: _____ Social Security. #_____

Employer's Name/Address/Phone: _____

Name and Address of Nearest Relative: _____
(Not Living With You)

WHO MAY WE THANK FOR REFERRING YOU TO US?_____

List Chiropractors You Have Seen:

1. Name: _____ Address: _____
   When? _____ What Did They Say Was Wrong? _____
2. Name: _____ Address: _____
   When? _____ What Did They Say Was Wrong? _____

List Medical Doctors Seen Within The Last Year:

1. Name: _____ Address: _____
   When? _____ What Did They Say Was Wrong? _____
2. Name: _____ Address: _____
   When? _____ What Did They Say Was Wrong? _____

Present Family Doctor: _____ Address: _____

List Your Symptoms According To **SEVERITY!**	Date started or for how long	Had it before? When?	Did it begin with an Injury?
1.			
2.			
3.			
4.			
5.			

Name of person responsible for payment: _____
Do you have insurance that covers chiropractic? No Yes
Name of insurance company:_____ policy #: _____

Surgery: (Please include all surgeries)

1. Type _____ When? _____ Doctor _____.
2. Type _____ When? _____ Doctor _____.
3. Type _____ When? _____ Doctor _____.
4. Type _____ When? _____ Doctor _____.

If you need more space, please ask at the front desk..

Accidents and/or injuries: (Especially those related to your current 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 an accident report form at the front desk.**

Mark the symptoms that you have now (N) or that you have had in the past (P):

___Allergies	___ Diarrhea	___ Low Back Pain	___ Pleurisy
___Alcoholism	___ Eczema	___ Low Blood Sugar	___ Pneumonia
___ Anemia	___ Emphysema	___ Malaria	___ Polio
___Arteriosclerosis	___ Epilepsy	___ Menstrual Cramps	___ Ringing in ears
___ Arthritis	___ Gall Bladder	___ Measles	___ Rheumatic Fever
___ Backaches	___ Gout	___ Migraine	___ Stroke
___ Cancer	___ Headaches	___ Miscarriage	___ Tuberculosis
___Convulsions	___ Heart Disease	___ Multiple Sclerosis	___ Thyroid Problems
___Constipation	___ Heart Attack	___ Mumps	___ Ulcers
___ Cold Sores	___ High Blood Pressure	___ Neck Pain	___ Upper Back Pain
___ Depression	___ Irregular Periods	___ Neuritis	___ Venereal disease
___ Diabetes	___ Leg Pain	___ Nervousness	___ Whooping Cough

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Davis Chiropractic Office may prepare any necessary reports and forms to assist me in making collection from an insurance company and that any amount authorized to be paid directly to Davis Chiropractic Office will be credited to my account upon receipt. 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 my care and treatment, any fees for professional service rendered to me will become immediately due and payable.

Patient's Signature: _____Date: _____

Guardian's Signature: _____ Date: _____

Information Taken By: _____ Date: _____