Wait Chiropractic

ABOUT YOU

Today's Date: _____/_____/_____

Patient Name: _____
LAST FIRST MI

Your Preferred Name: _____ ☐ Male ☐ Female

Birthdate: ___/___/_____ Age: ____ SS# _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Cell Phone # _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? _____

WELCOME

INSURANCE INFO

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone Number: _____

Insured's SS#: _____

Contract # (Mbr, Cust #): _____

Group #: _____

Insured's Name: _____

Relation: _____ Birthdate: ____/____/_____

Insured's Employer: _____

Please inform front desk of 2nd Insurance source

REASON FOR VISIT

The reason for this visit is a result of (Please circle): work, sports, auto, trauma, or chronic.

Explain what happened: _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ____/____/_____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

If so, please explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, by whom? _____ Phone #: _____