

Confidential Patient Case History

Please complete this questionnaire. Your answers will help us determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily to the treatment, we will not accept your case.
Thank you.

Patient Information

Patient Name: _____ Date: _____
Last Name First Name M.I.

Address: _____ Sex: Male Female

CITY STATE ZIP CODE D.O.B. _____

Marital Status: Single Married Widowed Separated Divorced AGE _____

Patient Social Security #: _____ Patient Driver's License # _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Spouse's Name: _____ Spouse's D.O.B. _____

Spouse's Occupation: _____ Spouse's Employer: _____

Email Address: _____ Number of Children: _____

Whom may we thank for referring you? _____

Phone Numbers

Home #: _____ Work #: _____ Ext: _____

Other Phone II (cell phone, pager, etc.): _____

Best time and place to reach you: _____

In Case of Emergency

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Ext: _____