

Reason For Visit

The reason for this visit is a result of (Please Circle):

Work Sports Auto Trauma Chronic

(Explain what happened) _____

Please describe the pain and its location _____

When did the condition begin? ____/____/____

Is the condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your (Please Circle):

Work Sleep Daily Routine

If so, explain _____

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

If so, 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, whom? _____ Phone # _____

In Event of Emergency

Emergency Contact _____ Relation _____

Home Phone _____ Work Phone _____

Who is your Medical Doctor _____ Phone # _____

Account Information - Person ultimately responsible for account

Name _____ Relation _____

Billing Address _____

City _____ State _____ Zip _____

SS # _____ D.L.# _____

Work Phone _____

Payment Method Cash Check

_____/____

Credit Card - Enter card number above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly
^{Initials} to the provider for services rendered. I fully understand I am solely responsible for any
balance not paid for by my insurance company (if offered at this office).