

PERSONAL HEALTH HISTORY

(Please print clearly, completing all the blanks spaces.)

Name: _____ Address: _____ City: _____
(FIRST) (MI) (LAST)

State: _____ Zip: _____ Cell Phone: _____ Work Phone: _____ Home: _____

e-mail address: _____ Sex: _____ Birthdate: _____ Today's Date: _____

Height: _____ Weight: _____ Social Security #: _____ Driver's License #: _____

Name of Employer: _____ Type of Work: _____

Your spouse's name and employer: _____

Your marital status: Single Married Separated Divorced Widowed

Who is responsible for the bill? Self Spouse Employer Insurance Medicare

How will payment be made? Cash Check Insurance Worker's Compensation Auto Insurance policy

In case of emergency contact: _____ Phone: _____

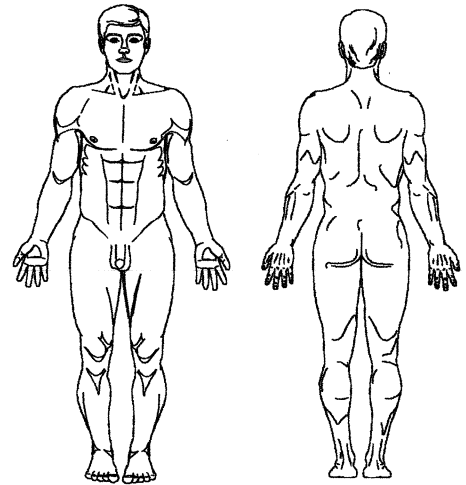
How were you referred to our office? _____

Race: ___ African American ___ Asian ___ Native American ___ Pac. Islander ___ White ___ Declined to state

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Declined to state

Please describe your major problems below and mark their exact location on the diagram.

In addition, if these are a result of a motor vehicle crash or a work injury, please complete the last page.



When did you first start having these symptoms? _____

What may have caused these symptoms? (example: fall, accident, lifting) _____

Has this problem been Getting Worse Getting Better Staying the Same?

Is there anything, that you do, that makes your condition worse? _____

Is there anything, that you do, that makes your condition better? _____

Have you ever had these symptoms before? Yes No If yes, please explain: _____

Have you had Chiropractic care in the past? Yes No Name: _____ Date: _____

Please describe what, if anything, has been done for your condition: _____

DO YOU HAVE A PACEMAKER? YES NO **ARE YOU PREGNANT?** YES NO **DUE DATE:** _____