Downtown Chiropractic
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PATIENT INFORMATION FORM
(PLEASE PRINT)

Name: _____ **Today's Date**:____/_____/_____

Birth Date: _____/_____/_____ **Age**: _____ **Gender:** Female Male

Social Security Number ☐☐☐☐☐☐☐☐☐

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Mother: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Guardian / Foster Parent: _____ Date of Birth: ____/____/____ Phone: (_____) _____

Who do you normally live with (check all that apply)? □ Father □ Mother □ Guardian / Foster Parent

□ Grandparent(s) □ Brother(s) / Sister(s) □ None of These

Marital Status: □ Married □ Separated □ Widowed □ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ **State** _____ **Zip** _____

Phone (_____) _____ **Mobile** (___)_____ **email(_____)**_____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Mobile (___)_____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ □ FULL-TIME □ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ____/____/____

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is a student at _____ □ FULL-TIME □ PART-TIME

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? □ YES □ NO Please check ALL that apply.

Did the condition or injury result from ***automobile*** **accident?** □ YES □ NO

Did it result from **a *work-related*** **accident or cause?** □ YES □ NO (briefly describe): _____

_____

--OVER--

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Approximately, when did your injury or condition occur? _____/_____/_____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? □ YES □ NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: _____/_____/_____

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Date of last physical examination? _____

What operations have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? □ YES □ NO

Describe: _____

What medications or drugs are you taking? _____

Have you ever suffered from:

□ Dizziness	□ Neck Pain	□ Digestive Disorders
□ Backaches	□ Headaches	□ Nervousness
□ Heart Trouble	□ Numbness	□ Sinus Trouble
□ Diabetes	□ Asthma	□ Anemia
□ Arthritis	□ Neuritis (Nerve pain)	□ Cancer
□ Hernia	□ Other_____	

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN

Do you have health insurance? □ YES □ NO Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ____/____/_____ Does the policy holder have the insurance through his/her employer? □ YES □ NO If yes, who is the employer? _____

How did you learn about us?:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the treating physician will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Downtown Chiropractic, Inc. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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 services rendered me will be immediately due and payable.

Consultation is FREE. There will be a charge on ALL examinations, x-rays, EMG and treatment rendered.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: _____/_____/_____

Guardian or Spouse's Signature:_____ __ Date: _____/_____/_____