Life Balance Chiropractic

Confidential Patient History

Name _____ Referred by _____ Date _____

Address _____ City/State/Zip _____

Home Phone _____ Cell _____ Work _____ Birth Date_____ Age_____

Email _____ SS# _____ Sex Height ___ Weight ____

Drivers License # _____ Marital Status Number of Children ____

Occupation _____ Employed by _____

Work Address _____ City/State/Zip _____

Spouses Name _____ Birth Date _____ SS# _____ Employer _____

Have you had chiropractic care before? No If yes, Doctor's name and date of care: _____

List your complaints in order of severity:

1. _____ How often _____ When did the most recent episode start? _____
2. _____ How often _____ When did the most recent episode start? _____
3. _____ How often _____ When did the most recent episode start? _____

Have these problems been getting worse or staying the same? _____

Have you at any time in the past suffered a work injury? No if Yes, what is the date of injury? _____

Have you been involved in an auto accident in the last 12 months? No if Yes, what is the date and details of the accident?

_____

If so, what care have you received for your injuries?_____

Please list any injury or illness that you are currently being treated for that is not listed above:

_____

Have you ever had any surgeries or been hospitalized? No yes please explain:

_____

Drugs you now take: ☐ Aspirin/Tylenol ☐ Painkillers ☐ Insulin ☐ Antacids ☐ Birth Control Are you pregnant? No

Other over the counter or prescription drugs you now take _____

How do you want to handle your problem? ☐ Temporary Relief ☐ Maximum Correction

What is your health philosophy? _____

Do you have any type of insurance? No Health Insurance Company _____

Policy Holder Info: Name:_____ **Birth date:**_____

Are you covered under any other health policy through yourself or your spouse? No If yes, please list insurance co mpany's name and **insured Name** and **Birth date:** _____

Method of payment for today's charges. ◯ Cash ◯ Check ◯ VISA/MC

I understand that all first visit charges are payable when service is rendered. I also understand that unless other agreements have been made, I am financially responsible for all services rendered to me including those that are not covered by my insurance company.

Patients Signature _____ Date _____