# Welcome to Imagine Chiropractic

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**_Confidential Patient Data_**

## PATIENT INFORMATION

Today's Date_______________

Date of Birth_________________

Name_____________________________________________

Address_____________________________City_______________State___ Zip________

Home Phone(___)____________Work Phone( __)____________Cell Phone(___)__________

E-mail Address______________________________________Age_______ ❑Male ❑ Female

Name of Spouse, Partner or Nearest Relative__________________________________

Phone_______________________________

Your Occupation____________________________ Your Employer___________________________

Referred to this Office by: ❑Friend/Family Member – Name_________________________

❑Yellow Pages ❑Mail ❑Office Location ❑Other________________

Payment for Services will be by: ❑Self ❑Health Insurance ❑Automobile Insurance

❑Worker's Compensation ❑Medicare ❑Other

## INSURANCE INFORMATION (Copy of insurance card or fill out the following)

Name of Insurance Co.______________________________Address_________________________

City_______________________State_______Zip_________Phone__________________________

Insureds Name________________Relationship_____________Insureds ID/SS#______________

Group/Policy Name__________________________Group/Policy # __________________________

Are you covered by more than one insurance company? ❑Yes ❑No Name ________________

## MEDICAL/FAMILY HISTORY S=Self M=Mother F=Father

(Please indicate which conditions have been experienced by the above by marking the appropriate boxes).

| S | M | F | S | M | F | S | M | F |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | ❑aids | ❑ | ❑ | ❑dislocated joints | ❑ | ❑ | ❑neck pain |
| ❑ | ❑ | ❑anemia | ❑ | ❑ | ❑epilepsy | ❑ | ❑ | ❑nervousness |
| ❑ | ❑ | ❑arthritis | ❑ | ❑ | ❑German measles | ❑ | ❑ | ❑numbness |
| ❑ | ❑ | ❑asthma | ❑ | ❑ | ❑headaches | ❑ | ❑ | ❑polio |
| ❑ | ❑ | ❑back pain | ❑ | ❑ | ❑heart trouble | ❑ | ❑ | ❑poor circulation |
| ❑ | ❑ | ❑bladder trouble | ❑ | ❑ | ❑reproductive disorders | ❑ | ❑ | ❑hepatitis |
| ❑ | ❑ | ❑bone fracture | ❑ | ❑ | ❑high blood pressure | ❑ | ❑ | ❑rheumatic fever |
| ❑ | ❑ | ❑cancer | ❑ | ❑ | ❑HIV/ARC | ❑ | ❑ | ❑rheumatism |
| ❑ | ❑ | ❑chest pain | ❑ | ❑ | ❑kidney disorder | ❑ | ❑ | ❑scarlet fever |
| ❑ | ❑ | ❑concussion | ❑ | ❑ | ❑bowel control loss | ❑ | ❑ | ❑serious injury |
| ❑ | ❑ | ❑convulsions | ❑ | ❑ | ❑menstrual cramps | ❑ | ❑ | ❑sinus trouble |
| ❑ | ❑ | ❑diabetes | ❑ | ❑ | ❑multiple sclerosis | ❑ | ❑ | ❑tuberculosis |
| ❑ | ❑ | ❑indigestion | ❑ | ❑ | ❑muscular dystrophy | ❑ | ❑ | ❑venereal disease |

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____________________________________________________________

## SURGICAL HISTORY

_____________________________________________________________Date:__________

_____________________________________________________________Date:__________

_____________________________________________________________Date:__________

## ACCIDENT HISTORY

❑Job ❑Auto ❑Other Injuries_________________________________________Date:__________

❑Job ❑Auto ❑Other Injuries_________________________________________Date:__________

❑Job ❑Auto ❑Other Injuries_________________________________________Date:__________