CHELSEA CHIROPRACTIC CENTER, PLC
901 TAYLOR STREET, SUITE C
CHELSEA, MI 48118

LAST NAME_____ **FIRST NAME**_____ **MIDDLE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

HOME PHONE(___)_____ **WORK PHONE(___)**_____ **SEX (M)**_____**(F)**_____

E-MAIL ADDRESS_____**(Your address will not be shared or sold)**

OCCUPATION_____ **EMPLOYER**_____

DATE OF BIRTH_____ **CURRENT AGE**_____

MARITAL STATUS S M W D (circle one) **NUMBER OF CHILDREN**_____

NAME OF SPOUSE (NAME OF PARENT, IF MINOR)_____

SPOUSE'S OCCUPATION_____ **SPOUSE'S DATE OF BIRTH**_____

WHO REFERRED YOU TO OUR OFFICE?_____

ARE YOU CONSULTING OUR OFFICE FOR **WELLNESS CARE**_____ **SPECIFIC PROBLEM**_____

IF FOR A SPECIFIC PROBLEM, PLEASE DESCRIBE_____

_____

_____

PREVIOUS TREATMENT_____

HOW DID THIS PROBLEM BEGIN?_____

IS YOUR CONDITION DUE TO AN INJURY FROM AN **AUTO ACCIDENT Y N** **WORK INJURY Y N**

WHEN DID YOU FIRST NOTICE THIS?_____

HAVE YOU EVER HAD THIS CONDITION BEFORE?_____

DESCRIBE_____

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? **YES**_____ **NO**_____

IF YES, PLEASE STATE WHERE AND WHEN_____

SIGNATURE_____ **TODAY'S DATE**_____