

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Birth Date ____/____/____ Age _____

Cell Phone _____ Marital Status _____ Spouse's Name _____

Work Phone _____ Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Email _____

How did you hear about us?

Referral (who?) _____

Spinal Screening (where?) _____

Yellow Pages

Saw Sign/Knew where we were

Reporter

Telemarketing Call

Insurance Directory

Other _____

COMPLAINTS

What is the reason for this appointment? _____

How long have you had this? _____ Is it getting worse? Yes/No

Is it constant _____ or does it come and go _____?

Have you had a similar condition in the past? Yes/No When? _____

What have you done for this problem? _____

What other health problems do you have? _____

What medications are you taking? _____

Have you had any surgeries? _____

Have you ever been diagnosed with cancer? _____

Your Primary Care Physician's Information

Name _____

Address _____ City _____ State _____

Phone Number _____ Date of last physical exam _____

Have you ever been in a work or auto accident? Yes/No When? _____

****Please give the receptionist your Health Insurance card so it can be copied****

Insurance Company (Primary) _____

Address _____ City _____ State _____

Policy # _____ ID # _____ Group # _____

Insurance Company (Secondary) _____

Address _____ City _____ State _____

Policy # _____ ID# _____ Group # _____

Any x-rays taken at this office will remain the property of this office. I authorize Shealer Chiropractic, P.C. to release information to my insurance company for payment. I authorize release of information to Shealer Chiropractic, P.C. from other facilities regarding treatment. The above statements are true to the best of my knowledge.

Patient Signature _____ **Date** _____