CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Date: _____

Full Name: _____

Name of Spouse or Guardian: _____

Address: _____
Residence and Mailing City/Town Province Postal Code

Home Phone: _____ Work: _____ Cell: _____

Birth date: _____ No. of Children ___ Pregnant? _____
Month/Day/Year

Occupation: _____

Employer's Name/Address/Phone: _____

Spouse's Occupation/Employer: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you to us? _____

List Chiropractors you have seen before:

1. Name: _____ Address: _____
   When: _____ What was the diagnosis? _____
2. Name: _____ Address: _____
   When: _____ What was the diagnosis? _____

List Medical Doctors consulted within the past year:

1. Name: _____ Address: _____
   When: _____ What was the diagnosis? _____
2. Name: _____ Address: _____
   When: _____ What was the diagnosis? _____

3. Present Family Doctor _____ Address: _____

4. Date of last physical examination: _____

List your problems or complaints according to severity of pain	Date started, or for how long	If you've had the condition before, when?	Did the problem begin with an injury?
1.			
2.			
3.			
4.			
5.			

Name of person responsible for payment: _____

Do you have insurance that covers Chiropractic care? Yes _____ No _____

Name of Insurance Company: _____ Policy No. _____

ID # _____

Surgery: *(Please include all surgery)*

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____
3. Type _____ When _____ Doctor _____
4. Type _____ When _____ Doctor _____

If additional space is needed, please continue on another sheet.

Accidents and/or injuries: *(especially those related to your present problems)*

1. Type _____ When _____ Hospitalized? Yes __ No __
2. Type _____ When _____ Hospitalized? Yes __ No __
3. Type _____ When _____ Hospitalized? Yes __ No __

Note: If you have recently been involved in an accident or had an injury, please request and fill out our accident report form. This may be obtained from the front desk.

Check the following conditions you may have had or now have:

_____ Alcoholism	_____ Diabetes	_____ Irregular Periods	_____ Pleurisy
_____ Allergy	_____ Diarrhea	_____ Low Blood Sugar	_____ Pneumonia
_____ Anemia	_____ Eczema	_____ Malaria	_____ Polio
_____ Arteriosclerosis	_____ Emphysema	_____ Measles	_____ Rheumatic Fever
_____ Arthritis	_____ Epilepsy	_____ Menstrual Cramps	_____ Ringing in ears
_____ Backaches	_____ Gall Bladder	_____ Migraine	_____ Sinus
_____ Back Pain	_____ Gout	_____ Miscarriage	_____ Stroke
_____ Cancer	_____ Headaches	_____ Multiple Sclerosis	_____ Thyroid Problems
_____ Cold Sores	_____ Heart Attack	_____ Mumps	_____ Tuberculosis
_____ Constipation	_____ Heart Disease	_____ Neck pain	_____ Ulcers
_____ Convulsions	_____ High Blood Pressure	_____ Nervousness	_____ Venereal Disease
_____ Depression	_____ HIV	_____ Neuritis	_____ Whooping Cough

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Amherst Chiropractic may 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 Amherst Chiropractic will be credited to my account on receipt. However, I clearly understand that all services rendered me are charged directly to me, and that I am personally responsible for the 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.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date_____

Information taken by _____ Date _____