

Welcome to Family Chiropractic

We are pleased to welcome you to our office. Please take a few minutes to fill this form out the best you can. If you have any questions we will be glad to help you. You have the right to leave any question unanswered.

Patient Information

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ Cell Phone _____

Home Phone _____ Email _____

Birthdate _____ Gender _____ Marital Status _____

Race _____ Are you Hispanic or Latino? _____ Preferred Language _____

Patient Employer _____ Occupation _____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone Number _____

Insurance Information

(Please fill out if you are **not** the Policy Holder)

Insurance Policy Holder name _____ Birthdate _____

Relation to Patient _____ Phone _____

Person Responsible Employed by _____

Insurance Company Name and Phone Number _____

ID # _____ Group # _____

Reason for Visit

Please circle all appropriate answers.

Have you ever seen a chiropractor? Y or N If yes, when and why? _____

What is the reason for this visit? Please describe your pain and its location:

Date symptoms began: _____ Have you had similar conditions in the past? Y or N

How often do you have this pain? _____

Have you seen a medical physician for this condition? Y or N If yes, When? _____

