CASHIERS CHIROPRACTIC
Confidential Health Record

Full Legal Name _____ **Cell#** _____
Home# _____
Other# _____

Local Mailing Address _____ City/State _____ Zip _____

Local Physical Address _____ City/State _____ Zip _____

Permanent Mailing Address (if different from local) _____

Permanent Physical Address (if different from local) _____

Age _____ Birth Date _____ Marital Status S M W D How many children? _____

E-Mail _____ Social Security # _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife/Husband _____ Occupation _____

Employer _____ Office Phone _____

Other Nearest Relative _____ Phone _____

Heard about our office through _____

For accidental injuries: ❒ Auto ❒ Work ❒ Home ❒ Leisure ❒ Sports ❒ Other

Please describe _____

Date symptoms appeared or accident occurred _____

Have you ever had the same or similar condition before? _____ Yes _____ No

Is this condition interfering with your ❒ Work ❒ Sleep ❒ Daily Routine ❒ Other

Previous Chiropractic care? ___ Yes ___ No By Whom _____

For What _____

When _____ X-Rays taken? ___ Yes __ No

Reason for consulting this office: _____ Eliminating symptoms or disease
_____ Preventing symptoms or disease _____ Maximizing health potential

List Present Complaints:
1. _____

2. _____

3 _____
Describe any treatment previously received for these complaints: _____

CONFIDENTIAL HEALTH RECORD

Do you have a pacemaker? _____

Do you have a port? _____

Do you have an insulin pump? _____

Any metal implants or prostheses? _____

Leisure Activites

	Sedentary	Strenuous
1.	_____	_____
2.	_____	_____
3.	_____	_____

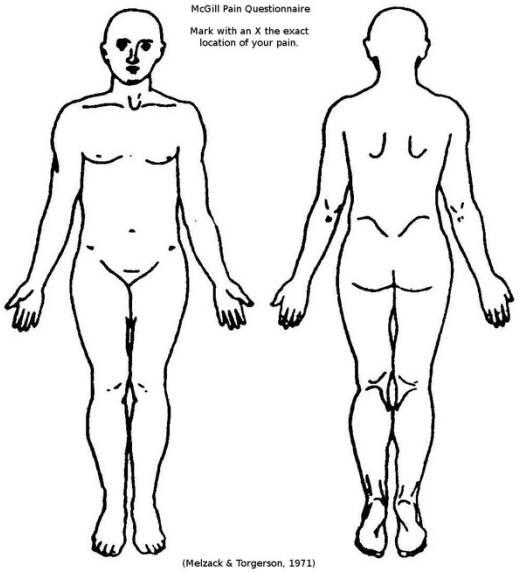
Date of last physical exam _____ By whom _____

For Women Only: Is there a chance you could be pregnant? _____ Yes _____ No

Date of last menstrual period _____

Pain Assessment

Please mark your areas of pain on the figures. Then mark the severity of your pain on a scale 0-10. O is no pain and 10 is the worst pain imaginable



Chiropractic is beneficial for many conditions of which you may not be aware, or which you may not associate with chiropractic. If you have any questions concerning a physical complaint, please ask us.

INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Cashiers Chiropractic will 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 Cashiers Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for 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 Spouses's Signature Authorizing Care _____ Date _____

Information taken by _____