SAND POINT CHIROPRACTIC CLINIC

CONFIDENTIAL PATIENT INFORMATION

Date **Name** **Social Sec #**

Sex **Marital status** **DOB** **Home phone** **Cell phone**

Address **City** **State** **Zip code**

Business phone **Company** **Occupation**

Name of nearest relative (not spouse) **Phone**

Who referred you to our office? _____

Is your visit due to an accident? _____ (If yes, please fill out an injury report)

Have you had previous chiropractic treatment? ____ If yes, name of Dr: _____

Briefly describe your symptoms _____

List other doctor(s) seen for this condition _____

Medical history (if any of the following are relevant to your medical history, please circle):

Headaches	Confusion/Depression	Mid back pain	Painful stiff joints
Sinus/Allergies	Shoulder pain	Low back pain	Epilepsy
Asthma	Arm/Hand pain	Pain down legs	Cancer
Dizziness	Arthritis	Gas/Bloating	Heart trouble
Tingling/Numbness	Shortness of breath	Bladder trouble	High blood pressure
Neck pain	Other _____		

Have you been tested HIV positive? ___ Are you pregnant? ___ Date of last menstrual period _____

Operations and dates _____

Have you been treated by a physician for any health condition in the last year? _____

Describe condition _____ Last physical exam _____

Medication _____ Are you allergic to any medication? _____

Insurance company_____ ID#_____

Patient's (Parent or Guardian's) signature _____