DOWNTOWN CHIROPRACTIC, P.C.

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. Thank You.

Date _____ Home/Cell _____ Email _____

Name _____ SSN_____

Street _____ City, State _____Zip_____

Age_____ DOB_____ Marital Status S M W D How Many Children_____

Occupation _____ Employer _____

Address _____ Office Phone_____

Name of Wife/Husband_____ Occupation_____

Employer _____ Office Phone_____

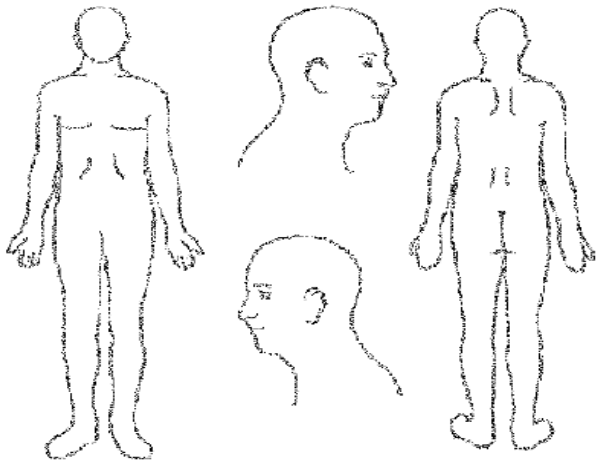
Other Nearest Relative_____ Phone_____

Heard about our office through_____

Have you ever been to a Chiropractor before Y/N

Have you ever been treat at one of our clinics Y/N

Please mark your areas of pain on the figures below



List present complaints, injuries and duration:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Remarks and details of any accident: _____
_____
_____
_____
_____

List other doctors consulted for present complaints and injuries:

Name _____ What kind of Dr._____ When consulted_____

Diagnosis_____ Treatment/X-rays_____

How long did you see the Doctor?_____ How frequently?_____

Results_____

Name _____ What kind of Dr._____ When consulted_____

Diagnosis_____ Treatment/X-rays_____

How long did you see the Doctor?_____ How frequently?_____

Results_____

Present family doctor _____

Date of last physical examination_____ By Doctor_____

What surgeries have you had

Type/When/Doctor/Remarks_____

_____

_____

List former serious accidents and falls: (auto, work, home, leisure, sports, other – circle one)

What/When/Symptoms/Treatment/Results_____

_____

_____

List broken Bones:

What/When/Remarks_____

_____

_____

List medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/Remarks_____

_____

_____

Environment

Work – (Please circle appropriate answer)

Seated/Standing – Work Bench/Desk/Counter/Other_____

Job involve – Lifting/Bending/Stooping/Twisting/Turning/Carrying/Walking/Standing/Other_____

Chair – Executive/Steno/Bench/Stool/Folding/Other_____ Shoes – High hells/Boots/Other_____

In order to help our patients obtain all insurance benefits for which they are eligible, we will need the following information completed.

GROUP HEALTH (Please complete in addition to Auto and Workmen's Comp. info)

Primary Co. _____

Address_____

Deductible $_____ Already Paid □ No □ Not Known. Percentage Insurance Co. pays (if known) _____%

Insured_____ Relationship to Insured_____

S.S# _____ Policy # _____ Group# _____

Secondary Co. _____

Address_____

Deductible $_____ Already Paid □ No □ Not Known. Percentage Insurance Co. pays (if known) _____%

Insured_____ Relationship to Insured_____

S.S# _____ Policy # _____ Group# _____