Bourland Chiropractic and Massage Clinic

OFFICE USE ONLY
Acct. No. ____________________
Date ____________________

CONFIDENTIAL PATIENT INFORMATION

PATIENT DATA

NAME ____________________ HOME PHONE ____________________

ADDRESS ____________________ WORK PHONE ____________________

____________________ CELL PHONE ____________________

CITY ____________________ STATE ____________________ ZIP____________________

EMAIL ADDRESS ____________________

SS# ____________________ DATE OF BIRTH ____________________ AGE ____________________

OCCUPATION ____________________ EMPLOYER ____________________

MARITAL STATUS ____________ SPOUSE'S NAME ____________________ PHONE ____________________

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU ____________________ PHONE ____________________

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS ____________________

____

MEDICAL HISTORY

PHYSICIAN ____________________ PHONE ____________________

IF ANY OF THE FOLLOWING ARE RELEVANT TO YOUR MEDICAL HISTORY, PLEASE √ THE ACCOMPANYING BOX:

☐ CANCER	☐ MUSCULAR DYSTROPHY	☐ RHEYMATIC FEVER
☐ POLIO	☐ MUTIPLE SCLEROSIS	☐ SCARLET FEVER
☐ TUBERCULOSIS	☐ CONVULSIONS	☐ NERVOUSNESS
☐ HIGH BLOOD PRESSURE	☐ EPILEPSY	☐ ASTHMA
☐ HEART TROUBLE	☐ CONCUSSION	☐ DIGESTIVE DISORDERS
☐ DIABETES	☐ DIZZINESS	☐ SINUS TROUBLE
☐ HEPATITIS	☐ ARTHIRITIS	☐ BACKACHES
☐ GERMAN MEASLES	☐ NEURITIS	☐ NUMBNESS
☐ VENEREAL DISEASE	☐ RHEUMATISM	☐ ANEMIA

DESCRIBE THE OPERATIONS YOU'VE HAD ____________________

DATES OF OPERATIONS ____________________

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐ YES ☐ NO ____________________

DESCRIBE CONDITION ____________________ DATE OF LAST PHYSICAL EXAM ____________________

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? ____________________

ARE YOU TAKING ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? ____________________

ARE YOU PREGNANT? ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD ____________________

EMERGENCY CONTACT ____________________ PHONE ____________________

WHOM MAY WE THANK FOR REFERRING YOU TO US?

☐ FRIEND ____________________ ☐ NEWS PAPER AD ☐ OUR WEBSITE ☐ RADIO AD ☐ OTHER ____________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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 ____________________

PARENT OR GUARDIAN'S SIGNATURE ____________________ DATE ____________________
(if minor)