Condon Chiropractic Office

CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Date: _____

Full Name: _____

Names of Wife, Husband or Guardian: _____

Address: _____
Residence and Mailing City State Zip Code

Telephone Number (____) _____ Social Security No. _____ -- ____ -- _____

Height: _____ Weight: _____ Drivers License No. _____

Marital Status: M S W D *(circle one)* Age____ Birthdate_____ No. of Children____ Pregnant?_____

Occupation: _____

Employer's Name / Address / Phone: _____

Spouse's Occupation / Employer: _____

Name and address of Nearest Relative: _____
(Not living with you)

Who may we thank for referring you to us? _____

List Chiropractors you have seen before:

1. Name: _____ Address: _____
   When: _____ What was the diagnosis? _____
2. Name: _____ Address: _____
   When: _____ What was the diagnosis? _____

List Medical Doctors consulted within the past year:

1. Name: _____ Address: _____
   When: _____ What was the diagnosis? _____
2. Name: _____ Address: _____
   When: _____ What was the diagnosis? _____
3. Present Family Doctor _____ Address: _____
4. Date of last physical examination _____

List your problems or complaints according to severity of pain	Date started, or for how long	If you've had the condition before, when?	Did problem begin with an injury?
1.			
2.			
3.			
4.			
5.			
6.			

Name of person responsible for payment: _____

Do you have insurance that covers Chiropractic care? Yes_____ No _____

Names of Insurance Company: _____ Policy No. _____

Surgery: *(Please include all surgery)*

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____
3. Type _____ When _____ Doctor _____
4. Type _____ When _____ Doctor _____

If additional space is needed please continue on another sheet.

Accidents and/or injuries: *(Especially those related to your present problems).*

1. Type _____ When _____ Hospitalized? Yes____No ____
2. Type _____ When _____ Hospitalized? Yes____No ____
3. Type _____ When _____ Hospitalized? Yes____No ____

NOTE: If you have RECENTLY been involved in an accident or injury, please request and fill out our accident report form which may be obtained from the Front Desk.

Check the following conditions you may have had or do have now:

____ Alcoholism	____ Diabetes	____ Irregular Periods	____ Pleurisy
____ Allergy	____ Diarrhea	____ Low Blood Sugar	____ Pneumonia
____ Anemia	____ Eczema	____ Malaria	____ Polio
____ Arteriosclerosis	____ Emphysema	____ Measles	____ Rheumatic Fever
____ Arthritis	____ Epilepsy	____ Menstrual Cramps	____ Ringing in ears
____ Backaches	____ Gall Bladder	____ Migraine	____ Sinus
____ Back Pain	____ Gout	____ Miscarriage	____ Stroke
____ Cancer	____ Headaches	____ Multiple Sclerosis	____ Thyroid Problems
____ Cold Sores	____ Heart Attack	____ Mumps	____ Tuberculosis
____ Constipation	____ Heart Disease	____ Neck Pain	____ Ulcers
____ Convulsions	____ High Blood Pressure	____ Nervousness	____ Venereal Disease
____ Depression	____ HIV	____ Neuritis	____ Whooping Cough

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Condon Chiropractic Office may 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 the Condon Chiropractic Office will be credited to my account on 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 Spouse's Signature _____ Date _____

Information taken by _____ Date _____