*DR. ROBERT CAPRILE, 181 MAPLE STREET, EAST LONGMEADOW, MA 01028 (413)525-6293*

**Confidential Patient Health Record** Date:____________________

## PERSONAL HISTORY

Name:______________________________ Birth Date: ____________________ Age: ________

Address: ____________________________ Single Married Widowed Divorced Separated

City: ______________________________ Number of Children: ____________________

State: ______ Zip Code: __________ Employer: ______________________________

Home Phone: ________________________ Business Phone: ______________________

Cell Phone: __________________________ Type of Work: ________________________

E-Mail Address: _______________________

Name of Spouse: ______________________ Spouses' Employer: ____________________

Spouse's Business Phone: ____________________

By Whom Were You Referred?________________________________________________

Name and Number of Emergency Contact:________________________ Relationship:______________

May we place your name on our referral board when you refer a new patient? YES NO

Health Insurance Co. Name: __________________Insured's Name: _______________Ins. DOB:__________

Primary Care Physician: ___________________________ Phone Number: ____________________

### PLEASE BRING ALL INSURANCE CARDS TO THE FRONT DESK

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I clearly understand and agree that all services rendered me are charged directly to me and understand that if I suspend or terminate my care and treatment, any fees for professional services to me will be immediately due and payable.

Signature: ____________________________________________ Date: ______________________

Signature authorizing care of minor: ___________________________ Relationship: __________________

### PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELLBEING.

_____ I am only concerned about relief of a particular symptom.
_____ I am only concerned about relief of a particular symptom, and preventing its return.
_____ I want optimum health and wellbeing on every level available to me.

## CURRENT HEALTH CONDITION

Reason For Consulting This Office: ____________________________________________________

Other Doctors Seen For This Condition: Yes__ No__ Who? ______________________________________

Previous Chiropractic Care: None___ Doctor's Name and Approx. Date of Last Visit:____________________________

**PLEASE COMPLETE BOTH SIDES. THANK YOU.**