# Welcome to Duboff Chiropractic Center

*Name* _____

*Address* _____

*City* _____ *State* _____ *Zip* _____

*Home Phone* _____ *Cell* _____

*Work Phone* _____ *Email* _____

*Age* _____ *Birthdate* _____ *# Children* _____

*Marital Status: M S W D Occupation* _____

*Spouse's Name* _____ *Contact #* _____

*Nearest relative & contact #* _____

***HEALTH INFORMATION*** *Have you had previous chiropractic care? Yes No*

*What is you major complaint?* _____

_____

*Other complaints:* _____

*How long have you had this condition?* _____

*Is it progressively getting worse? Yes No*

*Have you had this or similar conditions in the past? Yes No*

*Is your condition due to an auto accident or job related injury? Yes No*

*What activities aggravate your condition?* _____

*Other Doctors who treated this condition* _____

_____

*Please list surgical operations and years* _____

_____

*Please list any medications you now take* _____

_____

*Please list any previous injury/accidents* _____

**8124 Glades Road, Boca Raton, FL 33434 561-479-4069**

***MEDICAL HISTORY***

*Do you have a history of any of the following health conditions?*

| | | |
|---|---|---|
| *Heart Disease* | ____*Yes* | ____*No* |
| *Cancer* | ____*Yes* | ____*No* |
| *Strokes* | ____*Yes* | ____*No* |
| *Arthritis* | ____*Yes* | ____*No* |
| *Allergies* | ____*Yes* | ____*No* |
| *Dizziness* | ____*Yes* | ____*No* |
| *Headaches* | ____*Yes* | ____*No* |
| *Digestive disorders* | ____*Yes* | ____*No* |
| *Asthma* | ____*Yes* | ____*No* |
| *Respiratory problems* | ____*Yes* | ____*No* |
| *Diabetes* | ____*Yes* | ____*No* |
| *High blood pressure* | ____*Yes* | ____*No* |
| *Autoimmune disorders* | ____*Yes* | ____*No* |
| *Neurological disorders* | ____*Yes* | ____*No* |
| *Eye, Ear, Nose or Throat conditions* | ____*Yes* | ____*No* |
| *Skin problems* | ____*Yes* | ____*No* |

*Other* _____

***INSURANCE INFORMATION***

*Do you have Health Insurance?* ____*Yes* ____*No*

*If yes, name of insurance company* _____

*Are you covered by Medicare?* ____*Yes* ____*No*

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic 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 chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.*

*I will be paying today by* ____*Cash* ____*Check* ____*Credit Card*

*Patient's Signature* _____ *Date* _____

*Guardian's Signature* _____ *Date* _____

*Doctor's Signature* _____