## GENERAL INFORMATION

Date: _____

Please print your answers.

Name _____
(Last) (First) (Middle)

Address _____

City _____ State _____ Zip _____

Phone: Home (____) _____ Work (____) _____
Area Code Area Code

E-mail: _____

Do you have Chiropractic coverage that covers Chiropractic? Yes No

If Personal Injury, is it: Auto Work Related Other _____

Are you currently on Disability? Yes No

Are you: Married Single Number of Children _____

Who referred you here? _____

If married, spouse's name _____

Age: _____ Your Birthdate: _____ Occupation: _____

Driver's License #: _____

Employer: _____

What health care practitioners have you recently seen? _____

_____

Describe their findings: _____

_____

_____

Who did your last blood test? _____ When? _____

Do you have any silver dental fillings? Yes No If so, how many? _____

Do you have any root canals? Yes No If so, how many? _____

Do you ever use a cell phone? Yes No

Approximate the amount of time per week that you spend on a cell phone: _____