

# general information

**Please print your answers.**

Date: \_\_\_\_\_

Name \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_  
Area Code Area Code

E-mail: \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_  
Area Code

Do you have health insurance that covers Chiropractic? Yes No

If personal injury, is it: Auto Work related Other \_\_\_\_\_

Who referred you here? \_\_\_\_\_

Are you currently on disability? Yes No

Are you: Married Single Number of Children \_\_\_\_\_

Age: \_\_\_\_\_ Your birthdate: \_\_\_\_\_ Occupation: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Employer: \_\_\_\_\_

If married, spouse's name \_\_\_\_\_

List the health care practitioners you have recently seen, and describe each of 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: \_\_\_\_\_