

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: _____