Chiropractic Associates **Wm J Misenheimer DC**

Patient Name: _____ **Date:** _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____ Height_____ Weight_____ Blood Pressure_____/____

Sex M F Marital Status M S D W Date of Birth_____ _Age____ SS #_____

Name of Insurance Co_____

Social Security # of Insured_____ Date of Birth of Insured_____

Occupation_____

Employer_____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Major Complaint: Date symptom began_____

_____

_____

_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

_____

3. Past Health History:

A. Previous *illnesses* you've had in your life:

_____

B. Previous Injury or Trauma:

_____

Have you ever broken any bones? Which?

_____

_____

C. Allergies:

_____

D. Medications:

Medication Reason for taking

_____

_____

_____

_____

221 West Broadway
574-583-8890

Monticello, IN 47960
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Patient Name: _____ **Date:** _____

E. Surgeries:

Date Type of Surgery

_____

_____

_____

_____

F. Females/ Pregnancies:

Are You Pregnant? NO YES

4. Family Health History:

Associated health problems of relatives:

_____

_____

_____

5. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic Associates to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Wm J Misenheimer DC** for services performed.

Patient or Guardian Signature _____

Date_____

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