



CONFIDENTIAL PATIENT HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you.

Please make sure all information is legible and complete.

THANK YOU.

Name _____ Social Sec. _____
 Address _____ City _____ State _____ Zip _____
 Home # (_____) _____ Cell # (_____) _____ Birthdate ____/____/____
 Work # (_____) _____ Occupation _____ # of Children _____
 E-mail address: _____ (only used for our office purpose)
 Emergency Contact Name _____ Relationship _____
 Emergency Contact Phone # (_____) _____ Referred by _____

HEALTH INFORMATION:

Have you had previous chiropractic care? _____

If "yes" please give name _____

What is major complaint?

Other Complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and Goes

Is this condition interfering with your: Work Sleep Daily routine Other _____

How long has it been since you really felt good? _____

Other doctors that treated this condition? _____

List surgical operations and years:

Medications you now take:	Nerve Pills	Pain Killers	Muscle Relaxer	Tranquilizers
	Insulin	Heart Pills	Others _____	

Age of mattress: _____ Comfortable Uncomfortable

Do you wear Heel lifts Sole lifts Inner Soles Arch Supports

Have you been in an auto accident? Past year Past 5 yrs Over 5 yrs Never

Describe: _____

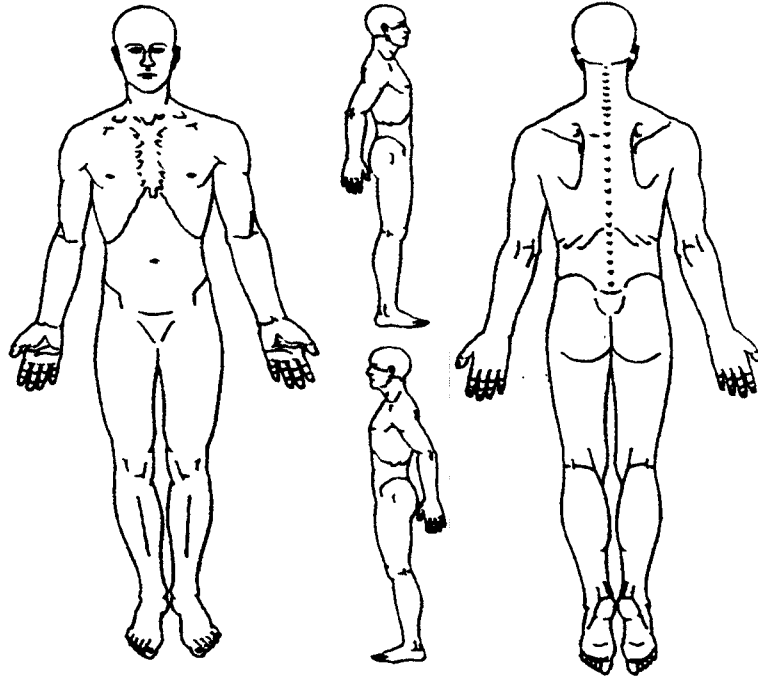
Have you had any other personal injury or accident? Past year Past 5 yrs Over 5 yrs Never

Describe: _____

Date of last physical examination: _____

Use letters below to indicate type symptoms and location.

A - ACHE	B - BURNING	S - STABBING
N - NUMBING	P- PINS & NEEDLES	O - OTHER



Have you ever suffered from: (please circle)

Dizziness Backaches Heart Trouble Diabetes Arthritis Headaches
Nervousness Sinus Trouble Neck Pain Digestive Disorder

INSURANCE INFORMATION

Do you have Health Insurance? YES NO If yes,
Company _____ Policy or member # _____
Group # _____

I understand and agree that health & accident policies are arrangement between an insurance carrier and myself. Furthermore, I understand that Gentner Chiropractic Center 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 Gentner Chiropractic Center will be credited to my account to receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature _____

Date _____

Witness Signature _____

Date _____