

Total Athleticare Patient History

CONFIDENTIAL PATIENT INFORMATION

DATE: _____

NAME: _____ REFERRED BY: _____
ADDRESS: _____ CITY: _____ STATE: _____
ZIP: _____ SSN: _____ BIRTH DATE: _____ AGE: _____
HOME: _____ CELL: _____ WORK: _____
E-MAIL ADDRESS: _____ MARITAL STATUS: S M D W
Name of Spouse: _____ Birth Date: _____

EMPLOYER INFORMATION

EMPLOYER: _____ OCCUPATION: _____ Full time / Part Time
ADDRESS: _____

PRIMARY CARE PHYSICIAN

NAME: _____ PHONE: _____
ADDRESS: _____ CITY: _____ ZIP: _____

CONDITION INFORMATION

CHIEF COMPLAINT: _____ DATE SYMPTOMS BEGAN _____

DUE TO: CHRONIC EMPLOYMENT AUTO ACCIDENT OTHER

Have you ever had a similar condition? Yes No If yes, when: _____

Have you seen a doctor for this condition? Yes No If yes, Name: _____

Date of last Physical Examination: _____ Operations? _____ When? _____

Serious Illness? _____ When? _____

Are you currently pregnant? Y N Date of last menstrual cycle: _____

What medication are you currently taking? _____

Do you have any known allergies? _____

DO YOU SUFFER FROM ANY OF THESE?

- DIZZINESS ARTHRITIS DIGESTIVE DISORDER HEADACHES
 DIABETS ANEMIA H/L BLOOD PRESSURE ASTHMA
 NUMBNESS HEART TROUBLE

INSURANCE INFORMATION

Company: _____ Insured's Name: _____

Insured's SS# _____ Insured's Employer: _____

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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 to provide me with chiropractic care, in accordance with this state's statutes. I assign directly to Total Athleticare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Total Athleticare to release all information necessary to secure payment. I authorize the use of this signature on all insurance submissions.

Patient Signature: _____ Date: _____