BROWN FAMILY CHIROPRACTIC
A Part of Your Lifestyle

Health History

Date _____

Name _____
Date of Birth _____
Height _____ Sex
Weight _____ ❑ Male ❑ Female
How did you hear about our office? _____

Home Phone _____ Cell Phone _____

Address _____

Email Address _____

Emergency Contact _____ Relationship _____ Phone _____

Doctor's Name _____

Doctor's Address _____

Name of Previous Doctor of Chiropractic _____
Date of Last Visit _____

Primary Symptom	Secondary Symptom
What is the primary symptom that prompted you to make this appointment?	What is the secondary symptom that prompted you to make this appointment?
When did the primary symptom begin?	When did the secondary symptom begin?
What caused you to have this primary symptom?	What caused you to have this secondary symptom?
What have you done to relieve/treat this primary symptom?	What have you done to relieve/treat this secondary symptom?

MEDICAL CARE

PATIENT'S NAME

Broken Bones ❑ Yes ❑ No Treatment ❑ Yes ❑ No Explain _____

Sprains/Strains ❑ Yes ❑ No Treatment ❑ Yes ❑ No Explain _____

Hospitalized ❑ Yes ❑ No Explain _____

Surgery ❑ Yes ❑ No Explain _____

Auto Accident ❑ Yes ❑ No Treatment ❑ Yes ❑ No Explain _____

Unconscious ❑ Yes ❑ No Treatment ❑ Yes ❑ No Explain _____

Eating Disorder ❑ Yes ❑ No Explain _____

Stroke ❑ Yes ❑ No Explain _____

Medications (e.g. cholesterol, high blood pressure, allergies) _____

Diagnosed Illnesses (e.g. diabetes, cancer, allergies) _____

Immediate Family History (e.g. cancer, stroke, diabetes) _____

WELLNESS CARE

Daily water intake in ounces _____

Sleep (hours/night) _____

Exercises (hours/week) _____

Supplements/vitamins _____

STATEMENT OF AUTHORIZATION

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctor sees fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment

Signature _____ **Date** _____