Thank you for choosing Washington Park Chiropractic. Please complete this confidential patient form.

Patient Information

Date______________

Name ______________________________ Date of Birth ______________________

Address ______________________________ SSN ______________________

City ____________________ State _____ Zip _____________ Gender: ❐ Male ❐ Female

Preferred Phone ____________________ Email ______________________________

Emergency Contact ____________________ *Relationship* _______________ *Phone* _______________

Financial and Insurance Information

Name of party responsible for payment

____

Insurance Carrier

Do you have health insurance? ❐ Yes ❐ No

Do you have a health savings account? ❐ Yes ❐ No

Are you eligible for Medicare (over age 65) ❐ Yes ❐ No

Employment Information

Employer ______________________ Occupation ______________________

Business Address ____

Hours of computer use daily? ______________ Right or Left Handed? ______ Hours worked each week?______

Hours driving daily? ______________ Describe a typical work day ______________________

Hours on your feet daily?

Who may we thank for referring you to our office? ______________________________

Reason for Today's Visit

Please rank your health concerns and rate their severity (on a scale from 1-10, 10 being the worst). **Severity 1-10**

1

2

3

4

Please list conditions you have been diagnosed with or are currently being treated for   Treating Practitioner

______________________________ ______________

______________________________ ______________

______________________________ ______________

Please list all fractures and dislocations and year ______________________________

List all prior surgeries, hospitalizations and year ______________________________

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Please list all allergies ______________________________

Please list all medications and supplements you are currently taking ______________________________