PATIENT INFORMATION

Today's Date: _____

NAME: _____ Date of Birth: _____ Age: _____

Address: _____ Home Ph#: _____

City, State, Zip: _____ Work #: _____
may we call you here: Y N

Occupation: _____ Marital Status: S , M , D , W

Emergency Contact: _____ Phone #: _____

How did you hear about us: _____ Have you received chiropractic care before: Y N

IS TREATMENT RELATED TO: Auto Accident Work Accident Other Accident

Will you be using insurance with us: Y N Name of insurance: _____

You, the patient, understand that this is a cash practice. If you so choose to use insurance, Dr. Jena Friedel's office will bill for you, but you will ultimately be 100% responsible for the payment of services in full. Your signature below shows that you understand and agree to these terms and that you authorize Dr. Jena Friedel's office to release your medical information to other medical providers and insurance companies if your medical care necessitates it.

Have you ever had the following:

	YES / NO
Heart disease (high blood pressure, clots, pacemaker, etc)	_____/_____
Kidney disease (dialysis, bladder, etc)	_____/_____
Lung disease (asthma, tuberculosis, shortness of breath, etc)	_____/_____
Gastrointestinal disorders (ulcers, hepatitis, liver disease, colon, etc)	_____/_____
Diabetes	_____/_____
Cancer of any sort	_____/_____
Ear-eye-nose-throat conditions (sinus, glaucoma, tonsils, etc)	_____/_____
Genitourinary conditions (infections, incontinence menopause, etc)	_____/_____
Pregnancies (miscarriages, births, currently pregnant)	_____/_____
Musculoskeletal conditions (arthritis, fibromyalgia, etc)	_____/_____
Stroke (including any vascular disease)	_____/_____

Do you smoke or use tobacco? Y N Do you consume alcohol? Never Some Moderate Heavy

List any allergies: _____

Past surgeries: _____

Current Medications: _____

List any illnesses that have or are affecting immediate family members: _____

_____