CONNOLLY CHIROPRACTIC CLINIC LLC

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Cell #: _____

Age: _____ Sex: ☐ M ☐ F Height: _____ Weight: _____ Marital Status: ☐ S ☐ W ☐ M ☐ D

# of Children: _____ E-mail: _____

Occupation: _____ Referred By: _____

Person to contact in an emergency: _____ Phone #: _____

Date of last physical exam: _____ With Whom? _____

Reported Findings: _____

Has your back or neck been x-rayed in the last 3 years? ☐ Yes ☐ No Where? _____

List all surgery, serious illness, hospitalizations (with year in brackets): _____

_____

_____

List all past dislocations, broken bones, and major dental work (with year in brackets): _____

_____

Have you ever suffered from:

☐ Dizziness	☐ Headaches	☐ Nervousness
☐ Backaches	☐ Numbness	☐ Diabetes
☐ Heart Trouble	☐ Asthma	☐ Anemia
☐ Breathing Problems	☐ Neuritis	☐ Cancer
☐ Arthritis	☐ Digestive Disorders	☐ Venereal Disease

Have you been treated for any health conditions in the last year? ☐ Yes ☐ No

If so, describe: _____

Purpose of this appointment: _____

_____

_____

Other people seen for this condition: _____

_____

What medications/drugs are you taking? (state reason in brackets following drug) _____

_____

_____

_____

Please write any additional information you would like Dr. Connolly to know here: _____

_____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment: _____

PATIENT AGREEMENT

I understand and agree that Connolly Chiropractic Clinic LLC does not file any insurance claims for me. Any health and accident insurance policies are an arrangment between my insurance carrier and myself. A receipt will be given to me upon request that I can file with my insurance carrier but not with medicare.

Guardian or Spouse's Signature Authorizing Care: _____

Patient Signature: _____ Date: _____