ZELLNER chiropractic center

Welcome to our Practice!

Today's Date:_____

PATIENT INFORMATION

Patient Name:_____ Preferred Name:_____

Birthdate: ____/_____/_____ Age:_____ Gender: ❑ Male ❑ Female

Social Security Number: _____ (for insurance purposes)

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Occupation:_____ Employer:_____

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widowed

Spouse/Partner's Name:_____

Children's Names & Ages:_____

Referred By:_____

INSURANCE INFORMATION

(If patient is primary insured you may skip this section)

Primary Insured Name:_____

Primary Insured Birthdate: ____/_____/_____ Social Security Number: _____

Employer:_____ Relation to Self:_____

Insurance Company Name:_____

Please continue on back.

REASON FOR TODAY'S VISIT

Is this an auto injury? ❑ Yes ❑ No Is this a work related injury? ❑ Yes ❑ No

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & Goes

Is this condition interfering with your: ❑ Work ❑ Activities ❑ Sleep ❑ Daily Life

Have you had a similar condition in the past? ❑ Yes ❑ No If Yes, please explain:

Have you been treated by a Medical Physician, Chiropractor or any other health care professionals for this condition?

If so, please list the providers you have seen:

PATIENT HISTORY

Please list any family history of spinal problems or other health concerns:

Please list any serious illnesses and/or operations you have had, with dates:

Do you routinely go for:

Spinal Check-ups? ❑ Yes ❑ No Physicals? ❑ Yes ❑ No

Dental Check-ups? ❑ Yes ❑ No Eye Exams? ❑ Yes ❑ No

How often do you exercise?:

What are your favorite forms of exercise?: