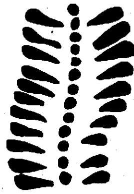


Salud
CHIROPRACTIC
443 Rohnert Park Expressway West, Rohnert Park, CA 94928
(707) 206-9717
"We Listen... We Care... We Get Results! Fast!

Confidential Patient Information

Date: ____________ **Name:** ____
Address: ________________________ **City:** ____________________ **State:** ___ **Zip:** _________
Home: ( ) _________ **Cell:** ( ) _______________ **Cell Provider:** _________________
SSN: ____________________________ **Email:** _________________________________

Preferred Method of Contact: Call Text Email Facebook Snail Mail

Date of Birth: _______/_______/_______ **Age:** ______ **Sex:** M F

Marital Status: Single Married Divorced Widowed Separated **# of Children:** ______

Name of Spouse (or parent): ____
Who may we thank for referring you to our office? _________________________

(Females only) Are you pregnant? Yes No Unsure

Employer: ____
Address: ____
City: ________________________________ **State:** ____ **Zip:** ________
Work: ( ) _________________ **Occupation:** ______________________________

**For your convenience, a complimentary insurance verification may be provided.
Simply provide us with a copy of your insurance card, and we'll verify your benefits.**

Have you ever had Chiropractic care before? Yes / No **If yes, when?** ____________

List your Chief Complaints in order of severity:
1. ____ How long? ________________
2. ____ How long? ________________
3. ____ How long? ________________
4. ____ How long? ________________

List other chiropractors or doctors consulted for these conditions:
1. ____
2. ____

Please list the following: Indicate medications (over the counter/prescriptions) you are currently taking: Aspirin/Tylenol Pain killers Muscle Relaxants Insulin
Others: ____

Surgeries/ Hospitalizations :) ____

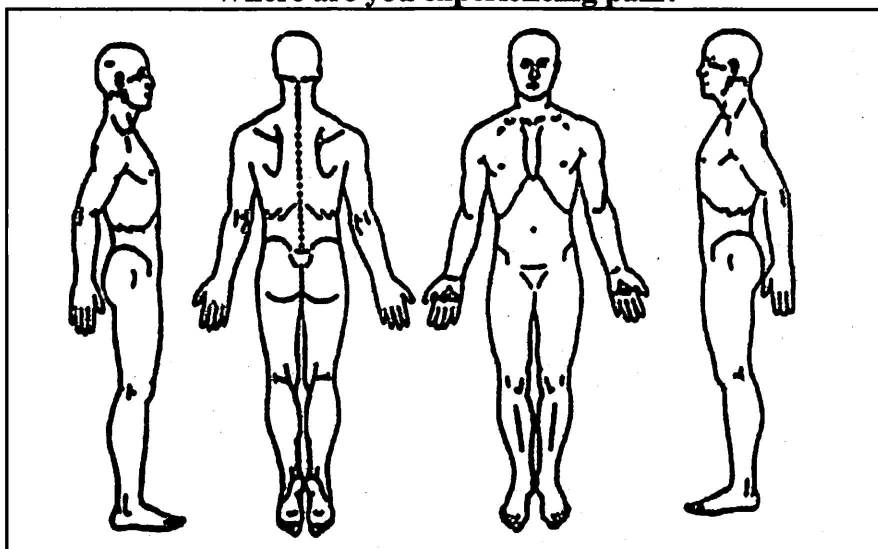
Fractures/ Broken Bones: ____

Auto Accidents (When and How Severe?) ____
____

Check any of the following you have had in the last six months:

( ) **Headaches**
( ) **Sinus Congestion**
( ) **Allergies**
( ) **Vision Problems**
( ) **Ear Aches**
( ) **Dizziness**
( ) **Heart Problems**
( ) **Lung Problems / Congestion**
( ) **Blood Pressure Problems**
( ) **Ankle Swelling**
( ) **Prostate / Sexual Dysfunction**
( ) **Menstrual Cycle Dysfunction**
( ) **Numbness**
( ) **Vomiting**
( ) **Frequent Nausea**
( ) **Abdominal Cramps**
( ) **Constipation**
( ) **Diarrhea**
( ) **Poor Excessive Appetite**
( ) **Excessive Thirst**
( ) **Painful / Excessive Urination**
( ) **Discolored Urine**
( ) **Diabetes**
( ) **Cancer**

COMPLETE THESE DIAGRAMS
Where are you experiencing pain?



NOTICE: Not all Patients require X-rays to determine the type and length of care. Is your examination warrants X-ray analysis, the following office procedure prevails:

1. All fees will be disclosed before any services are provided. All first visit charges are due and payable on the day services are rendered.

2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays for 7 years. The film itself is the property of this office. Films may be loaned to another facility with your authorization for 30 days only.

Name of Patient (printed):____________________

Signature of Patient: ____________________

If Guardian, Please State Relationship:____________________

Practice Representative: ____________________

Date:____________