GENTLE CARE CHIROPRACTIC

PATIENT HEALTH HISTORY

Today's Date: _______________

First Name: ______________________________ Last Name: ____________________________Middle initial:______

Date of Birth:___/____/___ Male: ___ Female: ____ e-mail address: ___________________________

Are you a: Florida Resident: _____ Seasonal Resident: ______ Vacationer: _____

Florida Address: ____ City: ______________________

Zip: _______________ Phone #: __________________ Cell #: __________________ Work #: _________________

Out of State Address: ____ City: ___________________________

State: ________________ Zip: _____________ Phone #: ______________

Which address is listed as your primary with your insurance? Florida: _______ Other: ________

Occupation: _________________________________ Employer: ___________________________________

Marital Status: M S D W Spouse's Name: ___________________________________

Emergency Contact: _____________________________________ Phone #: __________________________

Primary Physician: _________________________________ Phone #: ______________________

Specialists seen for current problem?: ____________________________________ MD DO ARNP PA LMT DC other

Phone #: ___________________________

Have you had previous chiropractic care? Y / N Chiropractor's Name: ___________________________

Last Appointment: _____________ Phone #: _______________

We are very willing to work with your other health care professionals. Do we have your permission to contact and/or update your other doctors if we feel it will aid in your care? Yes: ____ No: _____

Is your Condition due to an: Auto Accident: Y / N Work Accident: Y / N Other Accident: Y / N

How did you hear about our office? ____