BAKHSH CHIROPRACTIC CLINIC

Confidential Patient Information

Patient: _____ , _____ _____
Last *First* *MI*

Address: _____ City _____ State _____ Zip _____

Home #: _____ Date of Birth: __/__ / __ Age: ___ ☐ Male ☐ Female SSN: _____

Employer: _____ Occupation: _____ Work #: _____

Marital Status: ☐S ☐M ☐D ☐W Spouse/Guardian: _____ Home #: _____

Address *(if different)*: _____ City _____ State _____ Zip _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Responsible Party: ☐ Self/Spouse ☐ Parent ☐ Attorney ☐ Employer ☐ Other

Address: _____ City _____ State _____ Zip _____

Phone #: _____ Do you plan to use any insurace for partial payment of services? ☐ Yes ☐ No

Insurance Company: _____

TELL US ABOUT YOUR PAST MEDICAL HISTORY

Are you taking any medications (list): _____

_____

Do you have allergies? ☐ Yes ☐ No _____

Please circle if you have a FAMILY HISTORY of Diabetes, Cancer, Kidney Disease, Heart Disease, Gallstone, Liver Disease, High Blood Pressure, Stroke, Seizues, Back or Spinal Problems, Bone Disease, etc. _____

_____

Personal Habits: Tobacco _____ Alcohol _____ Caffeine _____

Please circle if YOU have any of the following: Diabetes, Cancer, Kidney Disease, Heart Disease, Gallstone, Liver Disease, High Blood Pressure, Stroke, Seizues, Back or Spinal Problems, Bone Disease, etc. _____

_____

Overall Health: ☐ Excellent ☐ Good ☐ Poor

Have you been hospitalized? (list dates and condition): _____

_____

Have you had any injuries or accidents in the past? _____

How did you hear about our clinic? _____

FEMALES ONLY: Are you taking birth control pills? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

I hereby state, to the best of my knowledge, that I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Signature: _____ Date: _____