

Welcome to  
Waldron Chiropractic

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Name Today's Date

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Address City St Zip

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Phone #'s: Home Work Cell Other

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Birthday / Age S-S# e-mail address

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Emergency Contact Relation Phone #

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Occupation Employer

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Referred by:

*We invite you to discuss with us any questions regarding our service. The best health services are based upon a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made.*

*I also understand that regardless of insurance coverage that I am ultimately responsible for my bill. I authorize the staff to perform any necessary services needed during evaluation and care. I also authorize the release of any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.*

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Patient signature Date

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Parent or guardian signature Date

# Welcome to Waldron Chiropractic

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

## **Tell us why you are here today:**

Have you ever had chiropractic care before? YES NO If yes, When \_\_\_\_\_

The reason for this visit is a result of: Work Injury Auto Accident Trauma Chronic Wellness

Other: \_\_\_\_\_

Date Problem started: \_\_\_\_\_ Is this condition getting worse? Yes No Constant Comes and goes

Please List your primary complaints in the order of severity (pain, symptoms, ECT.):

1. \_\_\_\_\_ for how long? \_\_\_\_\_

2. \_\_\_\_\_ for how long? \_\_\_\_\_

3. \_\_\_\_\_ for how long? \_\_\_\_\_

List any other doctors consulted for this condition: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you experience any of these complaints while working? \_\_\_\_\_ If yes, describe what activities at work that may be causing you experience these complaints? \_\_\_\_\_

Please list any surgeries/treatments with dates: \_\_\_\_\_

Please list any injuries or illnesses that you have had or have that are not listed above: \_\_\_\_\_

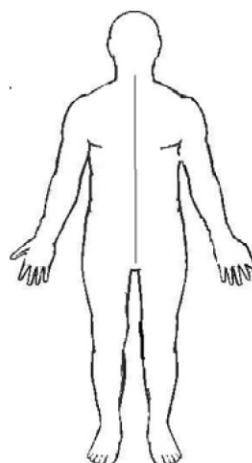
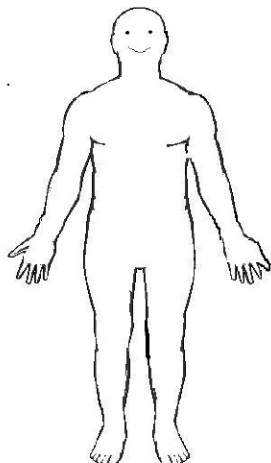
Please indicate medications over the counter/prescriptions you are currently taking:

Aspirin/Tylenol Pain Killers Muscle Relaxers Insulin Tranquilizers Birth Control

Other: \_\_\_\_\_

Is there any possibility that you are pregnant? Yes No Date of you last menstrual period: \_\_\_\_\_

**Please mark the areas of pain on the diagram below**



Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_