

Combs Chiropractic & Wellness Center

Name: _____ Date: _____

Address: _____ Apt. #: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: M S W D How Many Children? _____

Birth Date: _____ Social Security #: _____ Occupation: _____

Employer: _____ Employer Address: _____

Spouse's Name: _____ Spouse's Occupation: _____

Nearest Relative & Their Address: _____

Referred Here By: _____ Date of Last Physical Exam: _____

Have you Been Treated For Any Health Conditions In The Last Year? YES NO

If Yes, Please Describe: _____

Females: Are You Pregnant? YES NO

Plases List All Surgeries & Dates: _____

Please List Any Serious Injuries Or Accidents & Dates: _____

Please List All Current Prescription Medications & Vitamins: _____

The Purpose Of This Appointment: _____

Other Doctors Seen For This Condition: _____

Is This Problem Related To An Accident or Work Injury? Yes No

If Yes, Please Describe: _____

Name: _____

Check If The Condition Applies:

Have You Ever Suffered From:

- | | |
|--|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Deafness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Alcoholism |

Do You Currently Suffer With:

- | | |
|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficult Digestion |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Noise |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Poor Vision |
| <input type="checkbox"/> Neuritis | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Dyspepsia | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Irregular Menstrual Cycle |
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Excessive Flow |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Breast Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Fluid Retention |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Dry Skin |

Name of Person or Insurance Company Responsible for Payment: _____

Name of Insured: _____ Date of Birth of Insured: _____

Social Security # of Insured: _____

Patient's Signature: _____

Parent or Guardian Authorizing Care: _____