Parkhurst Chiropractic

New or Returning Patient Information:

Legal Name _____ Email _____

Address _____ City _____ State _____ Zip _____

Preferred Contact: (Work☐ Home☐ Cell☐) _____ Race: _____

Birth Date _____ Marital Status _____ Employer: _____

Birth Gender: _____ If female (due to x-rays) is there a chance you are pregnant & # of weeks?_____

Emergency Contact & Number: _____

Primary Care Physician: _____

Allergies to Medications: _____

Current Prescriptions (or bring in med list – Name & mg): _____

_____

How did you hear about us (circle)? Current Patient Dr. Referral Other:_____

Insurance Information:

Insurance Carrier:_____ Employer: _____

Contract #: _____ Group #: _____

Policy Holder's Name (if other than patient): _____

Insured's Name: _____ DOB: _____ Relationship: _____

PROBLEMS / MEDICAL HISTORY:	***Please mark an "X" on any that apply:***		
I am in good health		Kidney disease	
Arthritis		Liver problems	
Asthma		Lung disease	
Cancer		Muscle tension and/or pain	
Diabetes		Osteoporosis	
Fibromyalgia		Stomach problems	
Heart problems		Thyroid problems	
High Cholesterol		Vertebra fracture	
Joint problems			
Other:			

PAST SURGERIES:	***Please mark an "X" on all that apply or circle: Unknown/None:***		
Appendectomy		Lumbar Spine Surgery	
Cervical Spine Surgery		Mastectomy	
Heart Surgery		Thoracic Spine Surgery	
Hysterectomy		Gall Bladder Removal/Surgery	
Other:			