Gutierrez Family Chiropractic

NAME _____MALE/FEMALE DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

E-MAIL ADDRESS_____

BIRTHDATE_____ AGE_____SSN#_____-_____-_____

HOME PHONE #_____ CELL#_____ ALTERNATE PHONE #_____

EMPLOYER NAME_____ WORK# _____ext._____

SPOUSE/PARTNER NAME _____SPOUSE/PARTNER CELL #_____

PLEASE INDICATE POSSIBLE INSURANCE COVERAGE_____

WHAT COMPLAINT BRINGS YOU TO G.F.C.? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WAS IT THE RESULT OF: (AUTO ACCIDENT) (JOB INJURY)

WHAT TREATMENT HAVE YOU TRIED FOR THIS PROBLEM?

DESCRIBE_____

HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE YES NO

IF YES…APPROXIMATE DATE OF LAST ADJUSTMENT_____

DESCRIBE PHYSICAL ACTIVITIES INVOLVED WITH YOUR WORK OR LIFESTYLE_____

PLEASE GIVE APPROXIMATE DATE AND DESCRIPTION FOR ALL PAST:

AUTO ACCIDENTS _____

ALL OTHER FALLS AND INJURIES _____

FEMALE HISTORY: ARE YOU PREGNANT? ___NO ___YES DUE DATE:_____

I HEREBY WITNESS THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE ACCURATELY REPRESENTS MY COMPLETE HEALTH HISTORY.

BY SIGNING BELOW I AGREE I HAVE RECEIVED AND ACKNOWLEDGE ALL **HIPAA POLICIES**
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT
SIGNED_____ DATED _____

GUARDIAN/FINANCIALY RESPONSIBLE PERSON **IF UNDER 18**
SIGNED_____ DATED_____

PRINT NAME_____

*BY SIGNING BELOW I AGREE I HAVE READ AND ACCEPTED GUTIERREZ FAMILY CHIROPRACTIC'S
CONSENT FOR CARE
SIGNED_____ DATED _____

GUARDIAN/FINANCIALY RESPONSIBLE PERSON IF UNDER 18
SIGNED_____ DATED_____

PRINT NAME_____