

1. Name _____ Social Sec. # _____ Today's Date _____
2. Date of Birth _____ Age _____ Sex _____ Martial Status _____ Cell Phone _____ Home Phone _____
3. Address _____ Apt. or Space # _____ City _____ State _____ Zip _____
4. Who referred you to this office? _____ Your Occupation _____
Prior Patient, Yellow Pages, Newsletter, Other State Prior Occupation if Retired
5. Company name _____ Address _____ Business Phone _____
Length of present Employment _____ If Less Than 6 Months State Prior Employment _____
6. Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____
Spouse's Employer Address _____ Business Phone _____
7. Are you covered by health and accident insurance? Yes No Name of Insurance Company _____
Group Name _____ Has your deductible been met this year? Yes No Unsure
8. Are you covered by any other insurance plan? Yes No Name of Insurance Company _____
Group Name _____ Has your deductible been met this year? Yes No Unsure
9. In case of Emergency, Name of relative or friend NOT living with you (different address)
Name _____ Address _____ Phone # _____

10. Height: Feet _____ Inches _____ Weight: _____
11. Please describe the principal health problems for which you came to this office: _____

12. List any other health problems: _____

13. List any diagnosis(es) and type of treatment(s) _____

14. Have you previously received Chiropractic Care? Yes No If yes, when? _____
15. Have you had similar accidents or injuries before? Yes No If yes, explain: _____

16. Have you been treated for any health conditions by a physician in the past year? Yes No If yes, explain: _____

17. Are you currently under medication? Yes No if so, what kind? _____
18. List the appropriate dates of any surgery or unusual diseases you have had: _____

19. **AUTO ACCIDENT** - If this condition is due to an automobile accident, please answer the following:
20. Date: _____ Time: _____ AM PM Police report made? Yes No Who was ticketed? _____
21. Were you a driver or a passenger? _____
22. Please describe the accident: _____

23. Name of Insurance Co. that car in which you were riding was insured with _____ Policy # _____
24. Name of YOUR auto insurance co. if different from above _____ Policy # _____
25. Name of driver of other auto that was involved in the accident _____ Name of their insurance company _____
26. Do you have an attorney that has advised you in this case? Yes No Name _____

27. **WORK INJURY** - If your condition is due to a work related accident, please complete the following:
28. Have you notified your supervisor: Yes No Name of person you notified _____
29. Date of injury _____ Time: _____ AM PM Place _____
30. Description of injury and how it occurred _____

Please complete and sign other side

Health Questionnaire

MUSCULO-SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Ruptures
- Broken Bones

GENITO-URINARY SYSTEM

- Bladder Trouble
- Excessive Urine
- Scanty Urination
- Painful Urination
- Discolored Urine

FEMALE

- Vaginal Discharge
- Vaginal Bleeding
- Vaginal Pain
- Breast Pain
- Lumps on Breast

ARE YOU PREGNANT?

- Yes No

GASTO-INTESTINAL SYSTEM

- Poor Appetite
- Excessive Hunger
- Difficult Chewing
- Difficult Swallowing
- Excessive Thirst
- Nausea
- Vomiting Food
- Vomiting Blood
- Abdominal Pain
- Diarrhea
- Constipation
- Black Stool
- Bloody Stool
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble

NERVOUS SYSTEM

- Numbness
- Loss of Feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle Jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

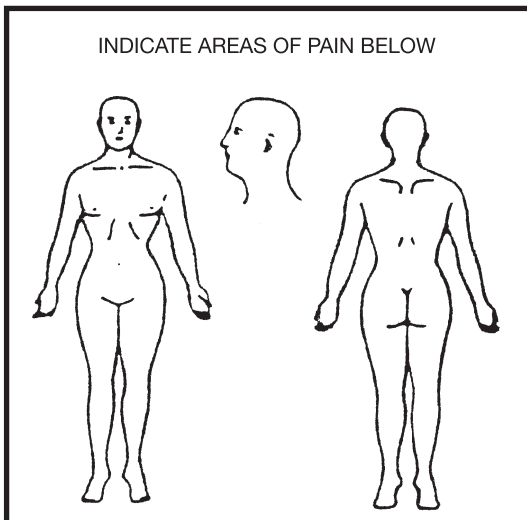
CARDIO-VASCULAR-

RESPIRATORY

- Chest Pain
- Pain Over Heart
- Difficult Breathing
- Persistent Cough
- Coughing Phlegm
- Coughing Blood
- Rapid Heartbeat
- Blood Pressure Problems
- Heart Problems
- Lung Problems
- Varicose Veins

EYE, EAR, NOSE and THROAT

- Eye Strain
- Eye Inflammation
- Vision Problems
- Ear Pain
- Ear Noises
- Hearing Loss
- Ear Discharge
- Nose Pain
- Nose Bleeding
- Nose Discharge
- Difficult Breathing Through Nose
- Sore Gums
- Dental Problems
- Sore Mouth
- Hoarseness
- Difficult Speech



Please list any other specific health problems or concerns which you feel we should be aware of _____

I also understand that if I am accepted as a patient by the physicians of Bronson Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

I authorize my insurance company/attorney to pay directly and/or lien to Bronson Chiropractic/Dr. Richard Bronson, D.C. (86-0670921) any and all monies due to them on my account. A photostatic copy of this statement shall be considered as valid as the original.

Date at Phoenix this _____ day of _____, 20 _____

Signature of Patient or Guardian _____