

BAKHSH CHIROPRACTIC CLINIC

Confidential Patient Information

Patient: _____, _____
Last *First* *MI*

Address: _____ City _____ State _____ Zip _____

Home #: _____ Date of Birth: ___/___/___ Age: ___ Male Female SSN: _____

Employer: _____ Occupation: _____ Work #: _____

Marital Status: S M D W Spouse/Guardian: _____ Home #: _____

Address (if different): _____ City _____ State _____ Zip _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Responsible Party: Self/Spouse Parent Attorney Employer Other

Address: _____ City _____ State _____ Zip _____

Phone #: _____ Do you plan to use any insurance for partial payment of services? Yes No

Insurance Company: _____

TELL US ABOUT YOUR PAST MEDICAL HISTORY

Are you taking any medications (list): _____

Do you have allergies? Yes No _____

Please circle if you have a FAMILY HISTORY of Diabetes, Cancer, Kidney Disease, Heart Disease, Gallstone, Liver Disease, High Blood Pressure, Stroke, Seizures, Back or Spinal Problems, Bone Disease, etc. _____

Personal Habits: Tobacco _____ Alcohol _____ Caffeine _____

Please circle if YOU have any of the following: Diabetes, Cancer, Kidney Disease, Heart Disease, Gallstone, Liver Disease, High Blood Pressure, Stroke, Seizures, Back or Spinal Problems, Bone Disease, etc. _____

Overall Health: Excellent Good Poor

Have you been hospitalized? (list dates and condition): _____

Have you had any injuries or accidents in the past? _____

How did you hear about our clinic? _____

FEMALES ONLY: Are you taking birth control pills? Yes No Are you pregnant? Yes No

I hereby state, to the best of my knowledge, that I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Signature: _____ Date: _____