Wagner Chiropractic Center
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CONFIDENTIAL PATIENT INFORMATION Date: _____
Name: _____ Social Security Number: _____
Address: _____City:_____State:_____Zip:_____
Home Phone: _____Cell Phone: _____ Work: _____
Email Address: _____
Age_____ Date of Birth_____ Martial Status: M○S○W○D○How many children?_____
Occupation/Employer: _____ Address_____
Name of Insurance Company_____
Insured's Name_____ SS#_____ DOB_____
Name of Spouse_____ Employer_____
Patients nearest Relative_____Address_____Phone_____
Referred By_____

Is this condition due to patient's employment? _____
Date symptoms appeared or accident happened_____
Patient ever had same or similar condition: YES_____ NO_____
If yes, when and describe: _____
_____
Have you lost any work? YES_____ NO_____
Date of last physical examination: _____ Female: Are you pregnant? YES_____ NO_____
What operations or illness have you had? _____
_____

Have you ever suffered from?

□Allergy	□Poor Posture	□Tuberculosis	□Nervousness/Depression
□Dizziness	□Sciatica	□Bruise easily	□Varicose Veins
□Headache	□Spinal Curvatures	□Hay Fever	□Bed-Wetting
□Fatigue	□Swollen Joints	□Nosebleeds	□Frequent Urination
□Loss of Sleep	□Colon Trouble	□Sinus Infection	□Kidney Infection/Stones
□Ulcers	□Diarrhea	□Cancer	□Prostate Trouble
□Itching	□Difficult Digestion	□Polio	□Cramps of Backache
□Numbness	□Hemorrhoids	□Pain Over Heart	□Excessive Menstrual Flow
□Arthritis	□Nausea	□Poor Circulation	□Hot Flashes
□Bursitis	□Asthma	□Rapid Heart Beat	□Irregular Cycle
□Foot Trouble	□Colds	□Slow Heart Beat	□Lumps in Breast
□Low Back Pain	□Deafness	□Anemia	□Alcoholism
□Ear Noises	□Stroke	□Diabetes	□Neck Pain or Stiffness
□Venereal Disease	□Enlarged Thyroid	□Chest Pain	□Low Blood Pressure
□Pleurisy	□Eye Pain	□Difficult breathing	□High Blood Pressure
□Spitting	□Failing Vision	□Swelling of Ankles	

Habit:	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Tingling or Numbness in:
□Shoulders □Hips □Arms □Legs
□Elbows □Knees □Hands □Feet

Are you wearing Heel Lifts_ _ Sole Lifts_____ Inner Soles_____ Arch Supports _ _

PLEASE PRINT

DO YOU:
Now take vitamins or minerals? YES_____ NO_____
Think you may need Vitamins or Minerals? YES_____ NO_____
Purpose of Appointment (Major Complaint) _____
_____
What activities aggravate your condition? _____
Is this condition interfering with your: Work_____ Sleep_____ Daily Activities_____ Other_____
How long has it been since you really felt good? _____
What do you believe is wrong with you? _____
Other Doctor's seen for this condition_____ When_____
Have you been treated for any health conditions in the last year? YES_____ NO_____
Describe_____
What medication or drugs are you taking? _____
Remarks and additional information_____

PAYMENT IS EXPECTED AT TIME OF VISIT!
Name of person responsible for payment_____

Are you insured? YES_____ NO_____ Company_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from my insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I further understand that for any reason my account is not paid in full, I am personally responsible for the service rendered to me. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and attorney fees incurred to effect collection of this account. I agree that reasonable collection fees shall be interpreted as 35% of any balance due at the time the account is sent to a collection agency.

Patient Signature: _____DLN:_____ Date: _____
Guardian or Spouse's Signature Authorizing Care_____ Date_____
Information Taken By_____ Date_____