

**Sawyer Chiropractic Group
Health History**

Name _____ Address _____

City _____ State _____ Zip _____ Home phn _____ Cell phn _____

Email _____ SSN _____ Date of Birth _____ Age _____

Height _____ Weight _____ Male Female Single Married Divorced # of children _____

Name of Spouse (or parent) _____ How were you referred to our office? _____

(Females only) Are you pregnant? Yes No Unsure

Employer _____ Address _____

City _____ State _____ Zip _____ Wk phn _____ Occupation _____

Have you ever had Chiropractic care before? _____ If yes, when? _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

Name of family physician _____

Do you ever experience any of these complaints while working? _____ If yes, describe the activities at work that may be causing you to experience these complaints: _____

Are there other activities, incidents, or events outside of work that may have caused these complaints? _____

If yes, please explain: _____

If this is due to an injury or accident, what is the date of injury? _____

Has this problem been getting better, worse, or staying the same? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Indicate medications (over the counter)/prescriptions you are currently taking: Aspirin/Tylenol Pain killers Muscle Relaxants Insulin Tranquilizers Birth Control Pills Others: _____

Please provide us with the following information so that we are able to submit billing for your chiropractic adjustments provided in our office.

Health Insurance: _____

Policy Holder Name: _____

Policy Holder: Self / Spouse / Parent

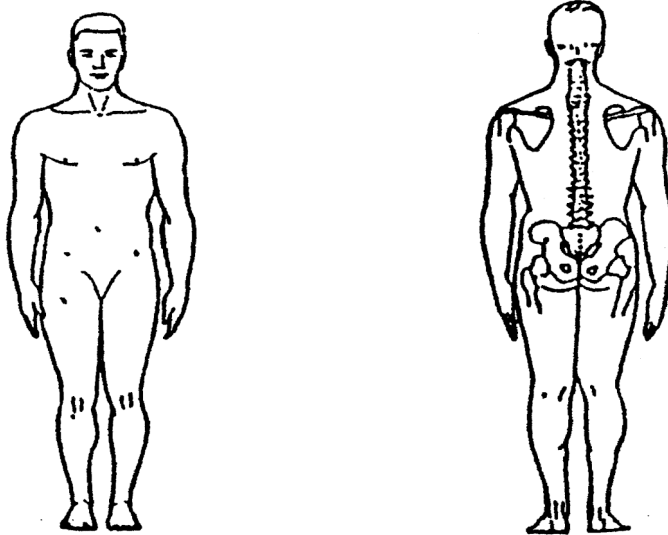
Policy Holder Date of Birth: _____

Policy Holder Gender: Male / Female

Policy Holder: Street Address: _____ **City, State** _____ **Zip** _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: CASH CHECK CREDIT CARD _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature _____ Date _____