

PERSONAL HISTORY

DATE: _____

NAME: _____ SOCIAL SECURITY # _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

BIRTHDATE: _____ AGE: _____ SEX: _____ HEIGHT/WEIGHT: _____

NAME OF EMPLOYER: _____ TYPE OF WORK: _____

TYPE OF INSURANCE _____ MARITAL STATUS: _____

NAME OF SPOUSE: _____ SPOUSE'S EMPLOYER: _____

TYPE OF INSURANCE: _____ ARE YOU COVERED BY THIS INSURANCE? _____

NAME & PHONE NUMBER OF NEAREST
RELATIVE (OUTSIDE OF YOUR HOME) _____

WHO IS RESPONSIBLE FOR YOUR BILL? Insurance Workman's Compensation Auto Insurance
 Self Other

PAST HEALTH HISTORY

PLEASE CHECK APPLICABLE ITEMS:

OPERATIONS: (SPINAL OR JOINT) _____

ACCIDENTS OR FALLS: (PLEASE DESCRIBE) _____

FRACTURES OR DISLOCATIONS: _____

HABITS: Sleep (Hours) _____ Exercise _____ Coffee _____ Tea _____ Alcohol _____ Tobacco _____

ARE YOU NOW TAKING ANY MEDICATIONS? (PLEASE EXPLAIN FOR WHAT) _____

ARE YOU PREGNANT? YES _____ NO _____

DO YOU UNDERSTAND THAT CHIROPRACTIC IS A DRUGLESS, NON-SURGICAL FORM OF HEALTH CARE? _____

ARE YOU DESIRING PATCH-UP CARE OR DO YOU DESIRE TO SPEND THE TIME NECESSARY TO OBTAIN A TRUE CORRECTION FOR THE PROBLEM, IF POSSIBLE? _____

HAVE YOU EVER HAD A NERVOUS BREAKDOWN? _____

ARE YOU HERE UNDER FALSE PRETENSES? YES _____ NO _____

CURRENT HEALTH CONDITION

Purpose of This Appointment _____

Other Doctors Seen For This Condition Yes No Who? _____

Type of Treatment: _____ Results: _____

When Did this Condition Begin? _____ Has This Condition Occurred before Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

*Please circle all the following symptoms you have now.
Please underline all the following symptoms you have had previously.*

Headaches

Neck Pain

Stiff Neck

Fainting/Dizziness

Pins/Needles in Arms, Hands, Fingers

Numbness in Arms, Hands, Fingers

Pain in Arms, Hand, Fingers

Back Pain

Pin/Needles in Legs, Feet, Toes

Pain in Legs, Feet, Toes

Numbness in Legs, Feet, toes

Chest Pain/Previous Heart Attack

High Blood Pressure

Pain Between Shoulder Blades

Asthma

Frequent colds

Sinus Trouble

Loss of Sleep

Loss of Weight

Difficult Breathing

Stomach Pains

Joint Swelling

Constipation/Diarrhea

Faulty Posture

Spinal Curvature

Painful Urination

Epilepsy

Cancer

OTHER _____

OFFICE FEES

Ortho/Neurological Exam.....	\$75.00	Rehab. Training	\$40.00 per
Manipulation	\$35.00-\$42.00	Computerized	
Medicare Exam	\$10.00	Muscle Testing	\$36.00 per
Therastim.....	\$20.00	Computerized Range	
Myofacial Release	\$35.00	of Motion Testing	\$23.00/per
Decompression Traction	\$25.00	X-Rays	\$70.00 and up

Please read this important information regarding any free offers.

In order to better determine if the health problems I am experiencing may be helped through chiropractic care; Tubbs Chiropractic may offer a free service(s) on my **FIRST VISIT ONLY**. The cost of any further dates of service such as (further examinations/xrays/treatment) are the patients responsibility. However, many insurance companies cover the cost of these services. The charges for these services are listed above. If you have a coupon for a free service; please present that at the time of your first visit. Certain restrictions do apply for medicare/medicaid patients. Co-payments and deductibles may be required by your insurance company and are due at time of service. We will be happy to qualify your insurance coverage for you.

*Offer good for 1st visit only

*Future treatment/exams excluded

*Medicare/Workers Compensation/Buckeye excluded from free offers

I understand the above "free offer" policy and fee schedule.

Patients Signature

Date