

1. Name \_\_\_\_\_ Social Sec. # \_\_\_\_\_ Today's Date \_\_\_\_\_
2. Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Martial Status \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
M F M, S, D, W
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

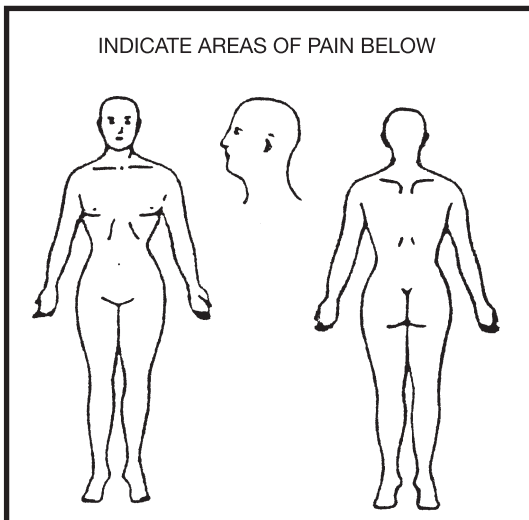
## CARDIO-VASCULAR-

### 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 \_\_\_\_\_