the CHIROPRACTIC ZONE
2812 E Meinhold Road, Langley, WA 98260
360-331-5565 phone 360-331-7122 fax

Patient Information Form

Today's date: _____

Name: _____ Refer to me as: _____
First Middle Last

Birthdate: _____ _____ _____ Age: _____ Sex: M F
Month Day Year

Status (please circle one): Single Married Separated Divorced Widowed

Number of children: _____

Employer: _____ Type of Work: _____ Years: _____

Home Mailing Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Where can we contact you? (Please check.) Home ___ Cell ___ Work ___

Emergency Contact: _____ Phone: _____
First Middle Last

What do you think caused your concerns and symptoms?
□ Sports-related □ Job-related □ Auto accident □ Unsure □ Other
If Other, please specify: _____

Date problem began and how? _____

Have you had this before? □ Yes □ No □ Unsure If Yes, when? _____
_____
_____

What can you not do because of your condition(s)? _____
_____

Have you seen other doctors or therapists for this? □ Yes □ No

If Yes, name of Doctor/s: _____ Type of Doctor/s: _____
_____ _____

When? _____ Where? _____ Tests done? _____
Type of care given? _____ Diagnosis given? _____
Did you find it effective? □ Yes □ No □ Unsure