

## PATIENT INFORMATION

**Thank you for choosing our office!**  
**Please provide the following information. All information will be confidential.**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

SSN \_\_\_\_\_ Male/Female \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

Current Status:    Minor    Single    Married    Divorced    Widowed    Separated

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

Spouse or Parent Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may be thank for referring you? \_\_\_\_\_ Phone \_\_\_\_\_

Person to contact in case of emergency? \_\_\_\_\_ Phone \_\_\_\_\_

Primary Physician's Name \_\_\_\_\_

Primary Physician Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

X \_\_\_\_\_

Signature of patient, parent or guardian (if minor)

Date

Have you ever had Chiropractic Care before?    Yes    No    If yes, when? \_\_\_\_\_

How long have you had your injuries? \_\_\_\_\_

Is this injury or illness work related?    Yes    No    If Yes, Date of Accident \_\_\_\_\_

Have you reported it to your employer?    Yes    No

Is this injury or illness related to an automobile accident?    Yes    No    If Yes, Date of Accident \_\_\_\_\_

### Insurance Information

Primary:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Company Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

Secondary:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Company Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X \_\_\_\_\_

Signature of patient, parent or guardian (if minor)

Date

**Woodbury Chiropractic Center**  
**856.848.1515**

223 S. Evergreen Avenue  
Woodbury, NJ 08096

**Have you ever suffered from:**

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

**Current Complaints (Continued)**

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache  
B=Burning  
N=Numbness

O=Other  
P=Pins & Needles  
S=Stabbing

