Patient History

Welcome to Rubin Family Chiropractic

Please take a few moments to fill out this form and sign on the bottom line.
Thanks! We will take GREAT care of you here!

Please Print

Name: _____ Date: _____
Phone Numbers:(home)_____(work)_____(cell)_____
Address: _____
City: _____ _____State: _____ Zip: _____
Date of Birth: _____ Age: _____ Male Female (circle one)
Number of Children: _____ Marital Status: _____ Name of Spouse: _____
Occupation: _____ Employed by: _____
Work Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____

How were you referred to our office? _____
Have you ever had Chiropractic Care? _____ If yes, when? _____

List your chief complaints in order of severity:
1. _____ For how long? _____
2. _____For how long? _____
3. _____For how long? _____

List other Doctors consulted for this condition:
1. _____ Address _____
2. _____ Address _____
3. _____Address _____

What do you do for fun? (sports, hobbies, etc.) _____
If female, are you pregnant? _____
Are you taking any prescription/non prescription drugs? _____
Have you ever had any operations? _____
Have you ever been in an accident/serious injury? _____
Do you have any heart problems/stokes/clogged arteries? _____

Is this injury or illness work related? _____ Have you reported it to your employer? _____
Is this injury or illness related to an automobile accident? _____
If yes, please provide the name of your:
Auto Insurance Co. _____ Policy #: _____
Claim #: _____

Do you have any type of Health Insurance? _____ Company: _____
If yes, please give us your insurance card so we can photocopy it!
Are you covered by Medicare? _____
Please give us your insurance card to photocopy for our files.

Patient Signature _____ Date _____
I agree to assume responsibility for any charges created by my chiropractic care, and give consent to be examined and/or treated by Dr. Rubin and his staff.