Patient History Form

Welcome to Rubin Family Chiropractic!
Please take a moment to fill out this form and sign the bottom.
Thanks! We will take GREAT care of you here!
Please Print

Name_____Date_____
Last First MI
Date of Birth_____ Age_____ Gender: Male Female Non-specified Preferred Pronoun_____
Address_____ City_____ State_____ Zip_____
Home Phone_____Cell _____ Cell Provider_____ Work _____
SSN_____ Email_____@_____
Number of Children_____ Marital Status_____ Name of Spouse/Partner_____
Emergency Contact: Name _____ Telephone number _____ Relationship _____
Preferred Language _____
Occupation_____ Employed by_____
Work Address_____ City_____ State_____ Zip_____

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.	a. For how long?
2.	b. For how long?
3.	c. For how long?

List other Doctors consulted for this condition:

1.	a. For how long?
2.	b. For how long?
3.	c. For how long?

Health Information:
What do you do for fun? (sports, hobbies, etc.) _____
If female, are you pregnant? Date of last menstrual cycle? _____
Are you taking any prescription/non-prescription drugs? If yes, please list them and what prescribed for _____
_____
Have you ever had surgery? _____
Do you have any heart problems/strokes/clogged arteries? _____
Do you have any other medical conditions? _____

Injury Information:
Is this injury or illness work related? _____ Have you reported it to your employer? _____
Have you ever been in an accident/serious injury? _____
Is this injury or illness related to an automobile accident? _____Date of accident _____
If yes, please provide the following information:
Auto Insurance Co. _____ Policy # _____ Claim # _____

Patient Signature_____

I agree to assume responsibility for any charges created by my chiropractic and additional care, and give consent to be examined and/or treated by Dr. Rubin, interns, and other chiropractors.