Ramsey Chiropractic Patient History Form

5424 S. Memorial Dr. Suite D-2 Tulsa, Ok. 74145-9003 (918) 665-3960

Name_____Date_____

Address_____City_____State_____Zip_____

Email_____Cell Ph ( )_____

Home Ph ( )_____BirthDate____/____/_____ Marital Status M S W D

Occupation_____Employer_____

Address_____City_____State_____

Work Ph ( )_____

Spouse_____Cell Ph ( )_____

Emergency Contact_____Cell Ph ( )_____

Family Medical Doctor _____

Referred to our Clinic by_____

Reason for this Appointment_____

Date symptoms appeared or accident happened_____

Have you ever had the same/similar condition? Y N If yes, when & describe_____

_____

List Surgeries & Dates_____

_____

Serious illnesses & Dates_____

Treated for any health condition in the last year? Y N If yes, describe_____

_____

Print Name_____

Is todays complaint caused by: Auto Accident Workers Compensation Other

Are you on any medications? Y N If yes, list_____

_____

Name of Primary Insurance Co._____

Name of Primary Insured _____ BirthDate_____/_____/_____

Health History (Circle only those that apply)

AIDS/HIV CATARACTS HEPATITIS OSTEOPOROSIS ALCHOHOLISM ANEMIA

CHEMICAL DEPENDENCY HERNIA PACEMAKER SUICIDE ATTEMPT THYROID

ALLERGY CHICKEN POX HERNIATED DISC PARKINSONS TONSILLITIS HERPES

PINCHED NERVE TUBERCULOSIS ANOREXIA PNEUMONIA TUMORS POLIO

APPENDICITIS EMPHYSEMA KIDNEY DISEASE TYPHOID FEVER ARTHRITIS GOITER

EPILEPSY LIVER DISEASE PROSTATE ASTHMA FRACTURES MEASLES PROSTHESIS

VAGINAL INFECTIONS BLEEDING DISORDERS GLAUCOMA PSYCHIATRIC CARE

VENEREAL DISEASE GONORRHEA WHOOPING COUGH BRONCHITIS MONONUCLEOSIS

GOUT RHEUMATIC FEVER SCARLET FEVER MULTIPLE SCLEROSIS BULIMIA MUMPS

STROKE CANCER HEART DISEASE MISCARRIAGE OTHER_____

Have you ever been in the hospital? Y N If yes, when & why?_____

_____

Have you ever seen a Chiropractor? Y N If yes, when?_____

Is there anything else you feel we should know?_____

Authorization & Release: I authorize payment of insurance benefits directly to Ramsey Chiropractic.
I authorize the doctor to release all information necessary to communicate with healthcare providers & payors to secure the payment of benefits.

Patient Signature_____Date_____