SOKRATIS DRAGONAS, D.C. P.C.

•Certified Chiropractic Sports Physician
•Certified By N.J. State Board
of Chiropractic Examiners

CONFIDENTIAL PATIENT HISTORY
(please print)

DATE:_____

PATIENT'S NAME:_____ SOCIAL SECURITY#_____

ADDRESS:_____ CITY:_____ STATE: _____ZIP:_____

AGE:_____ BIRTH DATE:_____ MARITAL STATUS: M S D W #CHILDREN:_____

HOME PHONE #:_____ CELL PHONE #:_____ WORK PHONE #:_____

OCCUPATION:_____ EMPLOYER:_____

EMPLOYER ADDRESS:_____

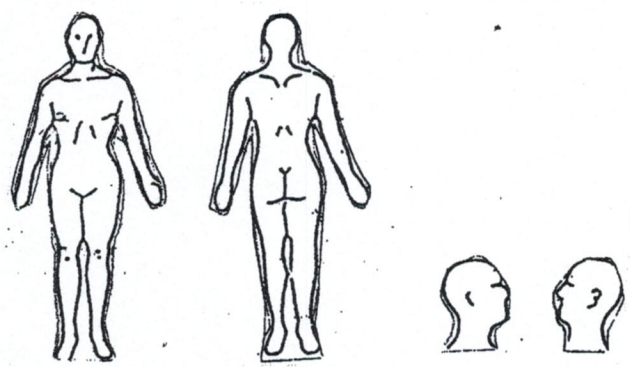
SPOUSE'S NAME:_____ OCCUPATION:_____

Purpose of this appointment:_____

Have you seen any physicians for this condition:_____Chiropractor _____MD _____None

What medications are you currently taking?_____

Please mark your areas of pain below:



List conditions that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

What functions are you unable to perform or induce pain upon performance? (example: sit, bend, walk, sleep, etc.):

1. _____
2. _____
3. _____
4. _____

Women: Are you or do you think you may be pregnant?_____Yes ___No

List surgical operations and years:

_____

Have you ever suffered from:

☐ Dizziness ☐ High Blood Pressure ☐ Neuritis ☐ AIDS
☐ Diabetes ☐ Back Aches ☐ Nervousness ☐ Asthma

☐ Digestive Disorder ☐ Sinus Trouble ☐ Headaches
☐ Heart Trouble ☐ Arthritis ☐ Allergies
☐ Neck Pain ☐ HIV positive

Date of last physician exam:_____
By whom: _____

Have you ever had Chiropractic care before?

☐ Yes ☐ No

Doctor's Name:_____

Have you been treated for any health condition by a physician in the last year?

☐ Yes ☐ No

Describe:_____
_____
_____

134 South Euclid Avenue, Westfield, NJ 07090 • Phone: (908) 233-4200 • Fax: (908) 301-0052

IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE COMPLETE THIS SECTION

DATE OF ACCIDENT: _____ WHERE (CITY & STATE): _____

Were you the ___driver ___ front seat passenger ___ back seat passenger (left/right) ___ pedestrian?

PLEASE DESCRIBE HOW YOUR INJURY HAPPENED:

_____

_____

_____

_____

_____

Was there anyone else in the vehicle at the time of accident? ___Yes ___ No If yes, whom? _____

Did you report your injury? ___Yes ___No If yes, to whom? _____

Did you go to the emergency room? ___Yes ___No Were you transported by ambulance? ___Yes ___No

Name of Hospital _____ X-rays taken? ___Yes ___No

Date(s) of hospitalization _____ Medication prescribed _____

Are you presently working? ___Yes ___No Dates of time lost from work? _____

Have you been treated by another physician for this injury? ___Yes ___No

If yes, name of doctor(s) & specialty _____

Are you being represented by an attorney? ___Yes ___No If yes, whom? _____

Do you or any member of your household own an automobile? ___Yes ___No Name of insurance _____

HEALTH INSURANCE:

Do you have health insurance? ___Yes ___No If yes, please provide the following information:

Name(s) of Insurance Company(s) _____ Policy#_____

Spouse's Insurance Company _____ Policy#_____

PAYMENT ACKNOLEDGMENT (**PLEASE SIGN**)

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRAGMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I ALSO UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY FORMS AND REPORTS NECESSARY TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNSERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED FOR ME ON MY DEPENDENT WILL BE IMMEDIATELY AND PAYABLE.

Patient Signature: _____ Date: _____

Insured Signature: _____ Date: _____

Parent, Spouse or Guardian's Signature: _____ Date: _____