HEIGHTS FAMILY CHIROPRACTIC

Align Your Health

CONFIDENTIAL CASE HISTORY

Please complete this questionnaire. Your answers will help us determine if our care can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate healthcare provider. If you need help with this form, please ask our front desk staff for assistance.

Name: ______________________________ Marital Status: ☐M, ☐S, ☐W, ☐D

Address: ______________________________ City: ______________ State: __________

Zip Code: ____________ Birth Date: __________________ S.S. # _________________

Cell Phone #: ________________________ Home Phone #: ________________________

Work #: ____________________________ Sex: ☐ Male, ☐Female

Occupation: _________________________ Employer: ___________________________

Whom may we thank for referring you? ____

If the above patient is a minor, please fill out the following information:

Person responsible for account: ____
(Parent and/or Guardian)

Address (if different): ______________________________ Birth Date: ____________

S.S #: ______________________________

I hereby state the above information to my knowledge is accurate.

Signature: ______________________________________ **Date:** __________________

WEBSITE MEMBERSHIP ENROLLMENT

The information on our website will help you **GET WELL** and **STAY WELL**. Please provide us with your email address so we can establish you as a member in our website. By joining our website, you authorize us to send monthly healthcare related emails to you. We will never out-source your email address to any company. You may opt-out at any time. Please review our complete privacy policy on our website.

Email Address: ____