127 E. Park Ave., Libertyville, IL 60048
847-680-3138
boscochiropractic.com

Confidential Health Information

Please allow our staff to photocopy your insurance card and drivers license. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Name	Social Security #	Today's Date	
Address	City	State	Zip Code
Age	DOB	Marital Status: M S W D How many children? ________	
Cell Phone #	Home Phone #	Email Address	
Occupation	Employer	Office Phone #	
Name of spouse	Occupation	Employer	
Emergency Contact	Relation	Phone Number	

Whom may we thank for referring you? ______________________________

Have you ever consulted a chiropractor before? ☐ Yes ☐ No If so, whom? ______________

Is this condition due to an injury or sickness arising out of employment? ☐ Yes ☐ No

Is this condition due to an injury or sickness arising out of an auto or other accidents? ☐ Yes ☐ No

Number of days lost from work ________ Date symptoms appeared, or accident happened ____________

Have you ever had the same or similar conditions? ☐ Yes ☐ No If Yes, when and describe: ____________

____

____

Primary Care Provider's Name: ______________________ City ______________

Date of last physical examination? ______________ Diagnosis with a serious illness? ☐ Yes ☐ No

What operations have you had? ______________________ Date ____________

______________________ Date ____________

Purpose of this appointment: ____________________

Other doctors seen for this condition: ____________________

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

Describe: ____________________

What medications or drugs are you taking? ____________________

Women Only Are you pregnant or is there a possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain

Date of last menstrual cycle: __________ Patient's signature: ____________________

PRIMARY COMPLAINT

The primary symptom that prompted me to seek care today is: ____________________

And are the result of: ☐ an accident or injury ☐ a worsening long-term problem ☐ an interest in wellness ☐ other: ____________________

Onset When did you first noticed your symptoms? ____________________

Prior interventions What have you done to relieve the symptoms?

☐ prescriptions medications ☐ over the counter drugs ☐ homeopathic remedies ☐ physical therapy
☐ surgery ☐ acupuncture ☐ chiropractic ☐ massage ☐ ice ☐ heat ☐ other

SECONDARY COMPLAINT

The secondary symptom that prompted me to seek care today is: ____________________

And are the result of: ☐ an accident or injury ☐ a worsening long-term problem ☐ an interest in wellness ☐ other: ____________________

Onset When did you first noticed your symptoms? ____________________

Prior interventions What have you done to relieve the symptoms?

☐ prescriptions medications ☐ over the counter drugs ☐ homeopathic remedies ☐ physical therapy
☐ surgery ☐ acupuncture ☐ chiropractic ☐ massage ☐ ice ☐ heat ☐ other

Additional Complaint(s): ____________________

What else should the doctors know about your current condition? ____________________

How does your current condition interfere with your:

Work or career: ____________________

Recreational activities: ____________________

Household activities: ____________________

Personal relationships: ____________________

What would be the most significant thing that you could do to improve your health?

____

____

In addition to the main reason for your visit today, what additional health goals do you have?

____

Patient (or Guardian's) Signature: ____________________ **Date:** __________