

POMEROY CHIROPRACTIC WELLNESS

Personal History

NAME _____ DATE _____
First Middle Initial Last

ADDRESS _____
Street City State Zip

PHONE: Home _____ CELL: _____ MARITAL STATUS: Circle One ~ S M D W

Date of Birth _____ If we are filing insurance: INSURED'S date of birth _____

E-MAIL (used for appointment reminders and newsletter ONLY): _____

OCCUPATION: _____

EMPLOYER _____ EMPLOYERS PHONE: _____

NAME OF SPOUSE/PARENT: _____

NAME AND AGE OF ALL CHILDREN _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

REASON FOR CONSULTING THIS OFFICE? _____

HAVE YOU SEEN ANYONE ELSE FOR THIS CONDITION? YES__ NO__

DR. SEEN: _____ WHEN? _____ OUTCOME? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES__ NO__

DATE OF LAST ADJUSTMENT _____ CHIROPRACTOR'S NAME _____

WHY THIS FORM IS IMPORTANT:

As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it is too late! Your answers will allow us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

**PLEASE FILL OUT THE FOLLOWING QUESTIONS COMPLETELY AND HONESTLY.
YOUR ANSWERS WILL HELP US PROVIDE YOU WITH THE BEST SERVICE.**

