APOLLO
Upper Cervical Chiropractic

Confidential Health Information

Name: _____ Best Phone #: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Marital Status (circle one) M S D W Age: _____

E-mail Address: _____

Occupation: _____ Employer: _____

Work Address: _____ City, St, Zip: _____

Spouse's Name: _____ # of Children: _____

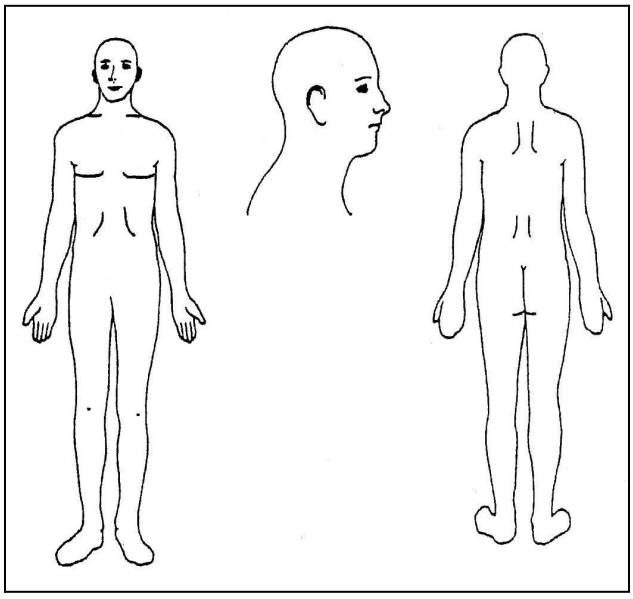
Who may we thank for referring to our office: _____

Have you ever had Chiropractic care before? Yes ☐ No ☐ Date of Last Visit: _____

_____***This office conforms to the current HIPPA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability. Initials*** _____

PLEASE MARK AN X WHERE YOUR PROBLEMS ARE ON THE DIAGRAM BELOW

Height: _____ Weight: _____



What is the reason for your visit today?

_____

_____

_____

_____

_____

List any medications that you are taking:

_____

_____

_____

_____

Turn over

Check any of the following you have ever had, even if they do not seem related to your current problem:

( )	Headaches	( )	Numbness
( )	Sinus Congestion/ Allergies	( )	Frequent Nausea/ Vomiting
( )	Vision Problems	( )	Abdominal Cramps
( )	Ear Aches	( )	Constipation
( )	Dizziness	( )	Diarrhea
( )	Heart Problems	( )	Poor / Excessive Appetite
( )	Lung Problems / Congestion	( )	Excessive Thirst
( )	Blood Pressure Problems	( )	Painful / Excessive Urine
( )	Ankle Swelling	( )	Discolored Urine
( )	Prostate/ Sexual Dysfunction	( )	Diabetes
( )	Menstrual Cycle Dysfunction	( )	Cancer

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

I authorize Apollo Upper Cervical Chiropractic PC to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____Today's Date:_____

Parent or Legal Guardian Authorizing Care: _____ _____

SOCIAL MEDIA

I consent to having my picture posted on social media if office photos are ever taken with your permission first.

Signature_____

THANK YOU FOR ALLOWING US TO SERVE YOU!