



Whole Body Health, Inc.

CONFIDENTIAL PATIENT HEALTH RECORD

Dear Patient: This information is considered confidential. We need this information because your answers will help us to determine if Chiropractic care can help you. If we do not sincerely believe that your condition will respond satisfactorily to Chiropractic care, we will not accept your case. In order for us to understand your condition properly, please be as accurate as possible in completing this form. Thank you.

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

E-MAIL: _____

PHONE :(H) _____ (CELL) _____ (W) _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: _____

CHILDREN? Y N NAMES & AGES _____

OCCUPATION: _____ EMPLOYER: _____

PATIENT'S NEAREST RELATIVE: _____ PHONE: _____

PERSON TO CONTACT IN EMERGENCY: _____ PHONE: _____

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

INFORMATION PERTAINING TO PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME & PHONE# (IF DIFFERENT FROM ABOVE): _____

ADDRESS: _____

DO YOU HAVE MEDICARE OR MEDICAID HEALTH INSURANCE? YES NO

NOTE: Whole Body Health, Inc. does not file insurance. You must request a "Super Bill" and file directly with your insurance company for reimbursement.