

Welcome to Gutrich Chiropractic!

Name: _____ SS # ____/____/____ Date of Birth ____/____/____
Phone (H):() _____ (C):() _____ (W):() _____
Address: _____ City: _____ State: ____ Zip: _____
E-mail address: _____ Referred by: _____

Occupation Information

Company Name and address: _____
Describe daily activities: _____

Insurance Information

Company Name: _____ Name of Policy Holder: _____
Claims mailing address: _____

Medical History

Height: ____ Weight: ____ Age: ____ Martial Status: ____ Number of children: ____
Previous fractures, sprains, dislocations: _____
Previous traumatic injuries, accidents, falls: _____
Surgical History: _____
Organic Diseases: _____
Current Medication: _____
Current Supplements: _____

Parental Medical History

Father: _____
Mother: _____

Have you been treated by any other chiropractor within the last 12 months? Y/N If so, please provide dates and problems for which you sought treatment.

Office Policies

Your appointment is reserved for you. We ask that you honor our 24 hour cancellation policy to avoid a charge of \$60. _____ (Please initial)

I understand that I am responsible for all fees incurred during treatment. I authorize release of these records to appropriate legal and insurance representative.

X _____ Date: _____