

**DEBLON CHIROPRACTIC OFFICES:**  
**Initial Entrance Form & History**

MARITAL: S M D W SEX: M / F Referred by \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SUBSCRIBERS NAME AND BIRTHDATE \_\_\_\_\_

ACCIDENT RELATED? Yes / No AUTO, WORK, OTHER \_\_\_\_\_

INSURANCE INFORMATION: Give cards to Denise to make copies of.

CURRENT PROBLEMS: DESCRIBE; \_\_\_\_\_

other problems; {circle and explain if needed}, headaches, cancer, arthritis, heart, diabetes, dizziness, sinus, nervousness, blood pressure, fatigue, numbness, allergy, digestive, bladder, bowel, backpain, neck, shoulder, arm, elbow hand, mid-back, lower back hip, knee, ankle, foot,

Have you been to a Chiropractor before? Yes / No Date of last adjustment? \_\_\_\_\_

Did you consult others for this problem? Yes / No Whom? \_\_\_\_\_

Family History of Problems: cancer, blood pressure, stroke, heart; \_\_\_\_\_

Any Surgeries / Past Problems {circle}: tonsils, appendix, hernia, heart, gallbladder, thyroid, spine, hysterectomy, cancer, other ? \_\_\_\_\_

DESCRIBE ANY PREVIOUS FALLS, ACCIDENTS, BROKEN BONES: \_\_\_\_\_

Prescriptions: nerve, pain, muscle relaxants, tranquilizer, insulin, heart, birth control, antibiotics, blood pressure, other \_\_\_\_\_

Over the counter: aspirin, Tylenol, Motrin, other \_\_\_\_\_ how often? \_\_\_\_\_

What have you done on your own to resolve your current problem? \_\_\_\_\_

**All services rendered to you are your responsibility. We will assist in processing insurance forms, and will accept fee schedules for those programs we provide for. Any deductibles or co-payments will be paid at time of service.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_