

# Patient Introduction

(Please print)

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Home/Work/Cell

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Insurance information \_\_\_\_\_

\_\_\_\_\_

What is your main health concern? \_\_\_\_\_

\_\_\_\_\_

When and how did it begin? \_\_\_\_\_

\_\_\_\_\_

What have you done to help yourself? \_\_\_\_\_

\_\_\_\_\_

How is it affecting the quality of your life? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other health concerns \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous chiropractor \_\_\_\_\_ When? \_\_\_\_\_

Why? \_\_\_\_\_ Were x-rays taken?  yes  no

What methods were used? \_\_\_\_\_

Briefly describe your diet \_\_\_\_\_

Medications (prescription and non-prescription) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Do you smoke?  yes  no

Surgery, hospitalization, or history of injury \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you prefer  whatever care is necessary for lasting correction, or  temporary relief only?

I understand that I am personally responsible for payment of charges for all services rendered to me. Any third-party coverage I might have is an agreement between that party and myself, which is separate from my agreement of responsibility to this office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Kojis Chiropractic, P.S. • 104 SE 107th Avenue • Vancouver, WA 98664**