



Integro Chiropractic
800 South Broadway, Suite 309
Walnut Creek, CA 94596
T: 925 952-9566 F: 925 952-9568

Patient Information

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

Sex: M or F Marital Status: S M D W

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

Who Referred You \_\_\_\_\_

Insurance:(please circle one) Self-Pay or Insurance

If Insurance, please complete info below.

Insurance Company \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_

Social Security No. \_\_\_\_\_

Is Subscriber the:(please circle one) Patient Spouse Parent

If not Patient, please complete info below.

Spouse/Parent Name \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Phone No(s) \_\_\_\_\_

\*\*Please let the office know if you have a secondary insurance.

Past Chiropractic Care? Y or N When? \_\_\_\_\_

Results \_\_\_\_\_

\_\_\_\_\_

Current Medical Doctor \_\_\_\_\_

Reason for your visit: (list up to 3 current problems, with No.1 being the most severe)

1. \_\_\_\_\_

Onset Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Intensity of pain today (scale 1 to 10) \_\_\_\_\_

2. \_\_\_\_\_

Onset Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Intensity of pain today (scale 1 to 10) \_\_\_\_\_ 1.

3. \_\_\_\_\_

Onset Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Intensity of pain today (scale 1 to 10) \_\_\_\_\_

Are your present problems due to an injury or accident? No \_\_\_ Yes \_\_\_

If Yes, was it: At Work \_\_\_ Auto Accident \_\_\_ Personal Injury \_\_\_ Other \_\_\_\_\_

Has the accident been reported? No \_\_\_ Yes \_\_\_

Reported to: Employer \_\_\_ Auto Insurance \_\_\_\_\_

Have you retained an attorney? No \_\_\_ Yes \_\_\_

Name & Address \_\_\_\_\_

Are you now or have you ever been disabled? No \_\_\_ Yes \_\_\_ When? \_\_\_\_\_

Why? \_\_\_\_\_

In Case of Emergency, we should contact:

Name \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis.

Patient/Guardian Signature: \_\_\_\_\_

Date \_\_\_\_\_