6365 Shier Rings Road, Suite A Dublin, OH 43016 614.764.4001 fax 614.764.4002
www.dublinfamilychiropractic.com

Name ____ Date of Birth _______________________

Address ____ Gender: Male_______ Female ________

City____ Home Phone_________________________

State_________________________ Zip________________ Cell Phone _________________________

Email Address ____

Marital Status: Sin__ Mar__ Div__ Sep__ Wid__ Other__

Employer ____ Occupation ______________________________

Emergency Contact:____

Phone number:______________________________ Relation:____________________________________

Work Address______________________________________ Work Phone_______________ X____

Do you have any allergies?(if so please list)____

Chief Complaint: Headache_____ Neck pain_____ Mid-Back Pain_____ Low Back Pain_____

Numbness/Tingling_____ Weakness______ Trouble Breathing______ Can't Move_______

Other____

How long have you had this condition? ____

How did this occur? ____ Date of injury ____________

Sports related? _____________ Work Accident? _______________ Auto accident? _______________

Have you ever received: Chiropractic: Y / N Massage Therapy: Y / N Acupuncture: Y / N

When?____________________________ Doctor/Therapist? ____

Condition you were treated for? ____

How did you hear of our office? ____

(If referred, please list the person's name so we may Thank them appropriately!)

Revised: September 2015

I authorize Dublin Family Chiropractic, Inc. to release any medical information necessary to bill my account to my insurance company or its authorized representative, Workers' Compensation, or attorney. I authorize payment of my medical benefits directly to Dublin Family Chiropractic, Inc.
I understand that I am financially responsible for charges not covered by this authorization.

Your Signature ____ Date _______________