Dockery Chiropractic

PERSONAL DATA

Date______________

Name ____Birthdate_________________

Address____

Home Phone___________________________ Cell Phone_____________________________

Employer__________________________________ Occupation_______________________________

Marital Status (circle) S M D W Name of Spouse______________________________________

Previous Chiropractor______________________________ Medical Doctor _______________________

Who referred you to our office ____

Present Concern____

HEALTH HISTORY

Previous serious illnesses ____

Chronic problems ____

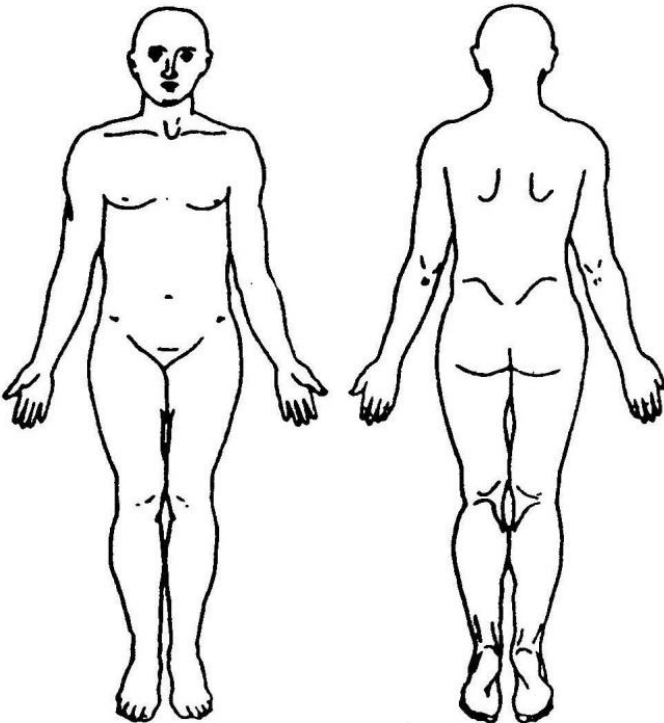
Surgeries including year ____

Current Medications ____

Please indicate **TYPE and LOCATION** of your symptoms.

A=Ache **P=**Pins & Needles **B=**Burning **S=**Sharp

N=Numbness **O=**Other



Please read, sign and date the following:

It is understood that Dockery Chiropractic is a cash practice and therefore does not take insurance. Payment is expected at the time service is rendered. To our patients, we understand that you may be on a budget. If our fee is beyond what your budget allows, speak with Dr. Dockery and he will adjust your fee accordingly.

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Patient Signature Date