Bates Family Chiropractic

457 Carmen Drive
Camarillo, CA 93010
(805) 389 - 9222

Name____Referred by__________________________________

Address________________________________City______________________State________Zip___________

Home Phone____________________Cell Phone__________________Work Phone__________________

Date of Birth______________Age_____Height________Weight______SSN________________ ☐ Male ☐ Female

E-mail____ If you do not wish to receive E-mail updates, please check here. ☐

☐ Single ☐ Married ☐ Other #of Children________ Name of Spouse (or parent)__________________________

Employer____Occupation________________________________

Address________________________________City______________________State________Zip___________

Have you ever had Chiropractic care before?________Doctor's name____________________Date of last visit__________

Family physician____________________________What city are they located in?______________________________

If you are experiencing any pain (neck, mid back, low back, headaches, etc.), health problems, and/ or other complaints, please list in order of severity and indicate how long you've been experiencing pain.

1.____For how long?________________________________

2.____For how long?________________________________

3.____For how long?________________________________

4.____For how long?________________________________

Has this problem been getting worse or staying the same?____

Currently or in the past have you ever experienced any of these complaints while working?____________________

What activities at work may be causing you to experience these complaints?______________________________

What other activities, incidents, or events outside of work may have caused these complaints?(if any)______________

____

Have you been involved in an auto accident in the last 12 months?__________Date of accident:_______________________

Do you have an attorney representing you for this auto accident?_________Attorney:______________________________

How many other passengers were in the car with you?____

Please list other doctors consulted for these conditions:____

Have you ever had any surgeries or hospitalizations?_________Please list:____

Please list any current or past injuries and illnesses not listed above:____

Please check all medications (OTC and prescribed) you are currently taking: ☐ Aspirin/ Tylenol ☐ Pain Killers

☐ Muscle Relaxers ☐ Insulin ☐ Birth Control Pills ☐ Sleeping Pills ☐ Anti-Depressants

☐ Others____

Health Insurance Company____Policy Number_______________________________

Policy Holder Name______________________________D.O.B.______________Relationship: ☐ Self ☐ Spouse ☐ Child