RUBIN CHIROPRACTIC CLINIC-248-476-1900

PERSONAL INFORMATION PLEASE PRINT

NAME_____ EMAIL_____

ADDRESS_____CITY_____ STATE_____ZIP_____

PHONE_____SOC. SEC. NO._____ DATE OF BIRTH_____

MARITAL STATUS_____SEX_____AGE_____NUMBER OF CHILDREN_____

OCCUPATION_____EMPLOYER_____TELEPHONE_____

NAME OF SPOUSE_____ BIRTHDATE_____

EMPLOYER_____

HOW DID YOU FIND US?_____

INSURANCE CO: _____ RELATIONSHIP TO THE PATIENTS_____
SUBSCRIBERS ID_____ example-(SELF, CHILD, SPOUSE)
SUBSCRIBER'S DATE OF BIRTH_____

EMERGENCY NOTIFICATION
NAME _____ TELEPHONE_____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.
Date_____ Patient's Signature_____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES
I hereby authorize RUBIN CHIROPRACTIC to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.
Date_____ Patient's Signature_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT_____

HOW DID IT HAPPEN? _____

_____

TODAYS CONDITION STARTED WHEN?_____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT ACTIVITIES LESSEN YOUR CONDITION?_____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____

IS THIS CONDITION INTERFERING WITH WORK?_____ SLEEP?_____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE?_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

Habits

- ❑ Alcohol: Type_____
  Amount_____
  Diet: Salt intake_____
  Fat intake_____
  Other_____
- ❑ Sleep: Difficulty falling asleep_____
  Continuity disturbances_____
  Early morning awakenings___
  Daytime drowsiness_____
  Other_____
- ❑ Smoking: Packs daily_____
  How long_____
  Interested in stopping?_____
- ❑ Exercise routine:____
  _____
  _____
- ❑ Caffeine: Coffee, cups daily_____
  Other_____