

8521 North 10th Street
McAllen, TX 78504
(1 mile North of Trenton)



Office: 956.686.WELL (9355)
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www.healthyRGV.com

Registration/Patient History

Patient Information

Patient Name: _____ Today's Date: _____

SSN: _____ DOB: _____ Age: _____ Sex: _____

Address: _____ City/State _____ Zip: _____

Email: _____ Employer/School _____

Home Phone: () _____ Cell: () _____ Work: () _____

Married Single Separated Divorced Widowed Minor

Spouse's Name _____ Phone: () _____

Whom may we thank for referring you to our office? _____

Accident Information

Is this condition due to an accident? Yes No If yes, Injury Date: _____

Type of accident: Auto Work Home Other _____

To whom have you made a report of your accident? Auto Insurance Employer Other _____

Attorney Name (if applicable) _____

Financial Agreement

Benefits quoted to us by your insurance are NOT a guarantee of payment. If your insurance pays the benefits they quoted us, the only services you will be responsible for are non-covered services, deductibles or co-pays.

I understand that I am financially responsible for all services/products rendered by WholeLife Chiropractic if not paid by my insurance company.

Signature of Patient, Parent, Legal Guardian or Personal Representative Relationship to Patient

Please print name of signature above Date

Patient Condition

Patient Name: _____

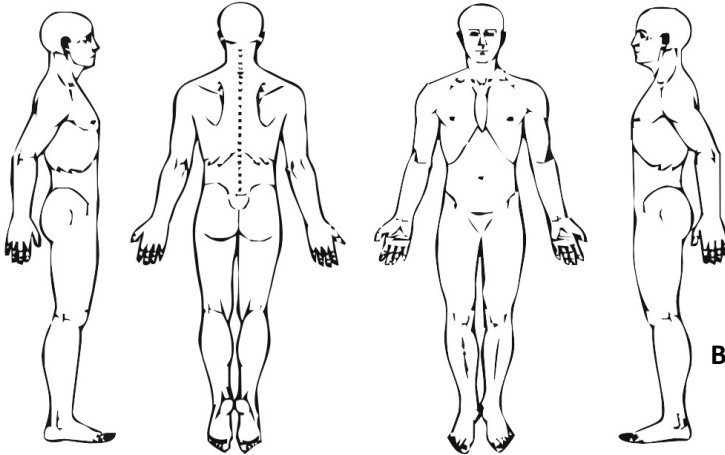
Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No

Does this condition interfere with your ability to sleep, work or play? Yes No

Please circle the area of complaints on the chart below and the types:



- Sharp Dull Aching
 Throbbing Burning Shooting
 Swelling Stiffness Cramps
 Numbness Tingling Other

Please rate your pain by circling a value below.



Health History

Do you smoke? Yes No If yes, how many packs per day? _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Exercise: None Moderate Daily Heavy

Please circle any that apply to your health history:

- | | | | | |
|--------------------|------------|---------------|------------------|------------------|
| AIDS/HIV | Bronchitis | Glaucoma | Herniated Disk | Prosthesis |
| Alcoholism | Cancer | Goiter | Herpes | Psychiatric Care |
| Anemia | Cataracts | Gonorrhea | Headaches | Stroke |
| Appendicitis | Diabetes | Gout | High Cholesterol | Tuberculosis |
| Arthritis | Emphysema | Heart Disease | Kidney Disease | Tumors, Growths |
| Asthma | Epilepsy | Hepatitis | Liver Disease | Ulcers |
| Bleeding Disorders | Fractures | Hernia | Pacemaker | Typhoid Fever |

Other: _____

Medications-Vitamins-Herbs-Supplements
