SUBMIT BY EMAIL PRINT FORM

CROCKETT CHIROPRACTIC CENTER
RONALD M. CROCKETT, B.S., D.C., P.C.
436 LANCASTER DRIVE NE
SALEM, OR 97301
503-371-9796

Date

Soc. Sec#

Name

Age Date Of Birth - -

Address

Home Phone - -

City State Zip Code

Cell Phone - -

Country

Work Phone - -

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Occupation

Employer's Name & Address

Name of Head of Family or Spouse

Occupation

Employer

Home Phone - -

Patient's Nearest Relative (other than above)

Business Phone - -

Who referred you to our office

Present symptoms:
What is your **major** problem

When did you first notice this problem

What brought it on?

What have you done to get relief

What are your **minor** problems?

Has there been a medical diagnosis? ◯ Yes ◯ No

If yes, by whom and when?

What was the diagnosis?

Have you consulted a Chiropractor for any other health problem? ◯ Yes ◯ No If so, when?

Name of Doctor What was the problem?

Payment is expected at the time of visit, unless other arrangements have been made with this office.

Name of person responsible for payment (if other than you)

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Are you insured? ◯ Yes ◯ No Company

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Any account that remains uncollected shall be forwarded to a collection agency and any additional costs incurred in the process of resolving the account will be added to the account and also be the responsibility of the patient. I hereby authorize Dr. Ronald Crockett to furnish my insurance company and/or attorney with any medical information requested.

Patient's Signature Date

Guardian or Spouse's signature Date

Past History

Have you ever had a similar problem? If yes, when?

Name of attending physician

Address

Have you ever had and operation? ◯ Yes ◯ No

If yes give the type and date of each.

Have you ever had any broken bones? ◯ Yes ◯ No

If yes, when?

Have you ever taken any bad falls? ◯ Yes ◯ No

If yes, when?

Have you ever sprained or dislocated any joints? ◯ Yes ◯ No

If yes, when?

Have you ever been in a previous car accident? ◯ Yes ◯ No

If yes, when?

Describe fully and state if you received any injuries

Family history of similar problems

List any medications you are currently taking

- ☐ Dizziness
- ☐ Headaches
- ☐ Nervousness
- ☐ Neuritis
- ☐ Digestive Disorders
- ☐ Anemia
- ☐ Diabetes
- ☐ Asthma
- ☐ Backaches
- ☐ Numbness
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Heart Trouble
- ☐ Arthritis
- ☐ Sinus Trouble