#_____

Dr. Dan Durrieu

DATE_____

NAME_____ SEX: M F BIRTH DATE_____

ADDRESS_____CITY_____ST____ ZIP CODE_____

HOME PHONE_____ CELL PHONE_____

SOCIAL SECURITY #_____ MARTIAL STATUS: S M W D

OCCUPATION_____

NUMBER AND AGES OF CHILDREN_____

E-MAIL_____ REFERRED TO OUR OFFICE BY:_____

NAME OF INSURANCE COMP:_____ NAME OF INSURED_____

Which pain or condition has brought you to our office?_____

_____

_____

_____

_____

_____

How long has it bothered you?_____

_____

_____

Please circle all that apply. SHARP or DULL CONSTANT or OCCASIONAL AM or PM

Does this pain radiate into an extremity or stay in one area?_____

_____

_____

_____

When was your most recent auto accident?_____

_____

Speed:_____ Front collision Side collision or Rear-end (circle one)

Was treatment received? Yes No If yes, where?_____

_____

_____

Are you considering filing a Lawsuit? Yes_____ No_____ if Yes, Name of Attorney_____

Do you currently have any Lawsuits pending? Yes____ No____ if Yes, Name of Attorney _____

What sport or recreational activities do you do?_____

_____

_____

When was your most recent stress or strain during your activity?_____

_____

_____

Was any treatment received? Yes No

Is there any other injury to your spine, past surgery, or health issues that the doctor should know about?_____

_____

_____

_____

_____

_____

HAVE YOU CONSULTED A CHIROPRACTOR IN THE PAST? Yes No

If yes, Name:_____ When was your last visit?_____

_____

_____

ARE YOU PREGNANT? YES NO

Fees are payable at the time of service. X-rays remain the property of this office.

PATIENT'S SIGNATURE_____

Doctor's Notes:_____

_____

_____

_____

_____