NATURAL WELLNESS
OF SOUTHERN CALIFORNIA

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CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:			**Date:**
Address: Street	City	State	Zip
Home phone:		**Work phone:**	
Cell phone:		**Email address:**	
Best time/place to contact you:			
Date of birth:		**Age:**	
No. of children:		**Pregnant?** Yes ☐ No ☐	
Height:		**Weight:**	
Driver's license number:			
Marital status: M S W D		**Spouse/guardian name:**	
Occupation:			
Employer's name & address:			
Spouse's Occupation/Employer:			
Name of person responsible for account:			
Do you have Medicare coverage? Yes ☐ No ☐			

Who may we thank for referring you?

_____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					