PEARSON
Chiropractic & Rehabilitation Center

WELCOME

The doctor and staff of Pearson Chiropractic Office welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate. PLEASE PRINT CLEARLY!

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Name you would like to be called:_____ Sex: M F Marital Status: Single Married Widowed Divorced

Address: _____ City, State, Zip: _____

SOCIAL SECURITY NUMBER: (MUST BE FILLED OUT). _____ Race:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Would you like to receive appointment reminders? Please fill in one or both.

Email address:_____ Cell phone carrier:_____

Employment Information

Employment status: Employed Unemployed Retired Part-time Student Full-time Student Other

Employer: _____ Occupation: _____

Responsible Party Information- If you are over the age of 18, please indicate self as responsible.

Relationship to patient: _____ Name (if other than self):_____

Address: _____ City, State, Zip: _____

Responsible Party's Phone#: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone #: _____

Is Your Illness or Injury Related to Any of the Following?

Employment Emergency Accident Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? YES NO

How Were You referred to Our Office?

By an Attorney By a Doctor By a Patient Yellow Pages Location Website Other

Please print the name of your source: _____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of Pearson chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process on information gathering so that the doctor can determine whether to accept me as a patient.

Date: _____ Signature: _____