OzarkWellness CHIROPRACTIC LIFE · HEALTH

About You

Name ____ Name you go by ____________________

Address ____

City ________________________________ State __________ Zip ______________________

Date of Birth ____________________ Age _______

Home Phone __________________ Work Ph __________________ Cell Ph __________________

E-mail ___________________________ Best # to reach you: Home / Work / Cell

Spouse/Loved One _________________________ Referred by __________________________

List Children if they are here for a Chiropractic evaluation:

Name _______________ Age _______ Name _______________ Age _______

Name _______________ Age _______ Name _______________ Age _______

Name _______________ Age _______ Name _______________ Age _______

When was the last time you saw a Chiropractor? days weeks months years never

What is your typical frequency of care of your spine and nervous system? ____________________

Are you healthier today than you were 5 years ago? Y N My overall health is 1 2 3 4 5 6 7 8 9 10

Reason for consulting this office:

I have no specific problem and am here to have my spine and nervous system checked for subluxations ☐

I have symptoms of a physical problem. Please describe. ______________________________

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Policies:

- We do not offer to do anything but detect and correct vertebral subluxations to allow the body to heal and maintain itself.
- We do not accept any form of insurance including Medicare/Medicaid. We are a cash only office. All fees are due at time of service.

Patient / Guardian Signature ______________________________**Date**____________________

Thank you for choosing Ozark Wellness Chiropractic. We look forward to a long, healthy relationship with you.