MADEIRA CHIROPRACTIC AND REHABILITATION

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PREVIOUS PROVIDERS & HEALTH HISTORY FORM ❶

Patient Name: ______________________________ Date________________

Understanding your health history is important. Please take the time and effort to fully and accurately provide us with the following information: **Please do not leave blank areas; mark N/A if appropriate**.

Current Family Care Provider:

Name	Address	Phone	Treatment Timeframe

Past Family Care Provider(s):

Name	Address	Phone	Treatment Timeframe
1.			
2.			
3.			

Other Medical Providers Seen in the Past 5 Years Pre-Dating the Accident/Collision:

Name	Address	Phone	Date(s)	Reason
1.				
2.				
3.				
4.				
5.				

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Other Medical Providers Seen any Time in Your Life Prior to the Accident/Collision for Conditions Similar to Those for Which You Currently Seek Treatment:

Name	Address	Phone	Date(s)	Reason
1.				
2.				
3.				
4.				
5.				

Patient Signature: ______________________________________

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Patient Name: ______________________________ Date________________

Prior Automobile Accidents with Injury:

Date	Location	Treatment Timeframe	Area(s) of Injury
1.			
2.			
3.			
4.			
5.			

Prior Work-Related Injuries:

Date	Location	Treatment Timeframe	Area(s) of Injury
1.			
2.			
3.			

Prior Slip/Fall Injuries:

Date	Location	Treatment Timeframe	Area(s) of Injury
1.			
2.			
3.			

Other Injuries of Relevance:

Date	Location	Treatment Timeframe	Area(s) of Injury
1.			
2.			
3.			

Patient Signature: ____

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