

ADVANCED FAMILY CHIROPRACTIC
Dr. Robert Berry
CONFIDENTIAL PATIENT INFORMATION (PLEASE PRINT)

Date _____

Name _____ SS# _____ - _____ - _____ Phone _____

Birth Date _____ Sex: M F Address _____

City _____ State _____ Zip Code _____

Employed By _____ Occupation _____

City/State _____ Work Phone _____

Marital Status S M W D Children _____

Whom may we thank for your referral? _____

Have you ever been to a chiropractor before? Y N If so, when? _____

List your chief complaints in order of severity:

1. _____ for how long? _____

2. _____ for how long? _____

3. _____ for how long? _____

Please list other doctors consulted for these conditions:

Is this an injury? Y N If yes, is it work related? _____

Have you reported it to your employer? Y N Is it related to an automobile accident? Y N

If this is an accident, please fill out the appropriate report form, which will be provided to you and
RETURN IT ON YOUR NEXT VISIT.

ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED.

The fee paid for treatment X-Rays is for analysis only. If x-rays are removed from the office the
Patient **MUST** sign a release form.