CHIROPRACTIC WELLNESS CENTER OF HUDSON

5111 Darrow Road
Hudson, OH 44236
330-656-1977
www.thehudsonchiropractor.com

PATIENT INFORMATION

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

Preferred name/nickname: _____

Address: _____ City: _____ State: _____

Social Security #: _____ Male / Female Marital Status: _____

Cell Phone #: _____ Home Phone #: _____

Email: _____

Emergency Contact Name: _____ Phone: _____

Employment: Student / Employed / Retired / Other

Occupation: _____ Employer Name: _____

HEALTH HISTORY

Describe current complaint: _____

_____

Surgical History: _____

Current Medications: _____

_____

Current Vitamins/Supplements: _____

_____

Please circle any of the following conditions that you have currently or have had previously:

Cancer Diabetes High Blood Pressure Arthritis Stroke

Epilepsy Asthma Dizziness High Cholesterol Fatigue

Multiple Sclerosis Heart Trouble Digestive Anemia

I voluntarily consent to receive medical and health care services to include diagnostic procedures, examination and treatment. I understand that The Chiropractic Wellness Center of Hudson is required to follow specific privacy regulations. A copy of the Notice of Privacy Practices is available to me at any time by asking a staff member.
I authorize The Chiropractic Wellness Center of Hudson to release any medical information needed to determine benefits payable by my insurance policy. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges.
I certify that I have read this form and understand its contents.

Name of Patient or Legally Authorized Person: _____

Signature: _____ Date: _____