



Hulsebus Chiropractic Clinics

www.hulsebuschiropractic.com

PLEASE PRINT • PLEASE FILL OUT ALL AREAS - IF NOT APPLICABLE PUT N/A

Today's Date _____

Last Name _____ First Name _____ Middle Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Sex (M)____ (F) ____

Occupation _____ Employer _____

Birth Date _____ Age _____ Marital Status (S M W D)

Social Security# _____ Drivers License # _____

Medical Doctor's Name _____

E-mail Address _____ Number of Children _____

Name of Parent or Spouse _____

How did you find out about our clinic? _____

Please list your major complaints and symptoms: _____

Previous Treatment: _____

What do you believe caused this condition? _____

Have you seen any other Health Care provider for this? _____

Is your condition due to an Auto Accident? _____ Work Injury _____ Personal Injury _____

When did you first notice this? _____

Ever had this condition before? _____

Describe _____

Have you been treated by a chiropractor previously? _____

Where and when? _____

Have you had any X-ray exposure in the past 2 weeks? _____

Is there a possibility of pregnancy? Yes _____ No _____

**WE WILL FILL OUT ALL INSURANCE FORMS FOR YOUR CLAIM,
YOU ARE RESPONSIBLE FOR YOUR BILL.
YOUR INSURANCE COMPANY WILL REIMBURSE YOU.**

Thank you for your cooperation.