Magnolia Chiropractic, P.A.

Providing Family Health Care for Our Community

139 S. Main Street
Irving, TX 75060

(972) 554-1511

www.MagnoliaChiro.com

Patient Information							
Last Name:		First Name:		M.I.:			
Address:				Apt No:			
City:		State:		Zip:			
Home #:		Work #:		Cell #:			
Email:		Occupation:		Age:			
DOB:	Day / Month / Year	Driver's License #:	State and Number	Social Security #:			
Sex:	☐ Male ☐ Female	Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed				
Spouse Info: If Applicable							
Last Name:		First Name:		M.I.:			

Patient Doctor & Referral Information	
Primary Care Physician:	
Other Physicians Who Care For You:	

Emergency Contact Information							
Name:		Relationship:					
Address:		City:		State:		Zip:	
Home #:		Work #:		Cell #:			

Patient Complaints (Please list your symptoms in order of severity)				
Complaint:	#1:	#2:	#3:	#4:
Date Began:	Day / Month / Year	Day / Month / Year	Day / Month / Year	Day / Month / Year
How It Began:				
Treatments Tried:				

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office?

Friend/Family Member? Name: _____

☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

Research shows that your spine should be checked regularly.
How many times have you visited a chiropractor in your lifetime?
#_____ ☐ Never

Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury?
☐ Yes ☐ No Date of Incident:_____

Prescription medication may cause various side effects, hide the severity of health problems and hinder the body's ability to heal.
What medications are you currently taking? _____

_____

If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations? ☐ Yes ☐ No

Would you like to receive our weekly health and wellness newsletter via e-mail? ☐ Yes ☐ No

I authorize the attending physician to release my medical information for consultation, referral, or insurance processing purposes.
I authorize my insurance company(ies) to pay benefits directly to the physician.

Patient Signature: _____ Date: _____