## BRUCE MIRON, D.C.

## **PATIENT HISTORY**

Name			Date		
Age Date of Birth Height Weight Phone (C)  Occupation Employer name & address  Marrial Status Name of Spouse No. of children  Who is responsible for your bill? ( ) Self ( ) Spouse ( ) Health Insurance - Submit card with paperwor ( ) Auto Insurance ( ) Workmen's Comp. ( ) Other  Name of Policy Holder Soc. Sec. No.  Relationship to you Date of Birth  Name of nearest relative not living with you Address  Phone (H) (W) Relationship  Was this injury related to: ( ) Work Accident ( ) Auto Accident  When was the last time you saw a chiropractor? Dr.  In the spaces provided, please indicate which conditions apply to you using (O) for past conditions or (X) for present conditions:  Fractured bones (Where?)  Auto accidents  (a) -0 + year ago (b) -1 -5 years ago (c) More than 5 yrs. ago Other accidents/falls  Knocked unconscious Neck pain or stiffness L R Anthrise Back curvature Mental or emotional disorders Arthrise Diabetes Head seems to heavy Swellen or painful joints Convulsions/epilepsy Difficulty or pain in excessive: San problems Shoulders feel tired Difficulty or pain in excessive: Shoulders for in excessive: Shoulders for the day seems to heavy Head or or stiffness L R Read seems too heavy Head or or stiffness L R Renders or sti	Name	Phone	(H)	(W)	
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