Your Family Chiropractor

Dr. Tom K. Jensen
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(605) 371-3346 ~ (605) 371-9109

Date: ______________________ Staff Name: ___________________________

Patients Name: ______________________________	Chief Complaint: __________________________
Address: __________________________________	Home Phone: _____________________________
City ______________State _____Zip __________	Cell Phone: ______________________________
Social Security #: ____________________________	Email: __________________________________
Date of Birth: ________________________	Age: _________ Marital Status: M S W D
Occupation: _________________________________	Employer: _______________________________
Referred By: _________________________________	Ins. Company: ____________________________
ID#: __________________ Group#:____________	Ins. Phone: _______________________________
Name of Insured: ____________________________	Date of Birth: _____________________________

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? ___ Yes ___ No

Family Physician: ____________________________________ Name of Facility: ______________________________

Person to contact in case of emergency (Name and Phone): ____

What operations have you had? ____ When? _________________
____ When? _________________

Serious Illness: ____ When? _________________
____ When? _________________

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds ___
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: ____________________________________

What is your goal in our office? ____
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At **Your Family Chiropractor** we strive to provide the best chiropractic care and customer service in our industry. It is our goal to help as many people as possible to end pain or sickness they may be experiencing, and help our patients maintain mobility for a lifetime. Because we choose to keep care affordable for our patients, we do not advertise for new patients. The majority of new people we help come from referrals from patients just like you! Our best compliment is a referral! If you enjoy your care here, please help spread the word. Tell family, friends and co-workers about our office. When you refer someone to our office we would love to say "**Thank you**!" Please tell us your t-shirt size, address where you could receive a special item during the day, and favorite stores or restaurants. Thank you for choosing Your Family Chiropractor!

T-shirt size: ________________ Favorite places: ____

Work place: ________________________ Work address or daytime address: ______________________________

____ ___________________________
Signature of Insured / Guardian Date