



# Bagwell Chiropractic Clinic

Dr. Buford Wayne Bagwell, D.C.

## New Patient Information & History

### Personal Information

<b>Last Name</b>	<b>First Name</b>	<b>Home Phone</b>	<b>Cell Phone</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Email Address</b>	<b>Marital Status</b>	<b>DOB</b>	<b>Date</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Occupation</b>	<b>Employer</b>	<b>Phone</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>How did you hear about Bagwell Chiropractic Clinic?</b>			
<input type="text"/>			

### Insurance Information

<b>1st Insurance Company</b>	<b>Policy #</b>	<b>Group #</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>2nd Insurance Company</b>	<b>Policy #</b>	<b>Group #</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Primary Insured's Information (If Other Than Patient)</b>		
<b>Name</b>	<b>Employer</b>	<b>DOB</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please allow receptionist to copy your insurance cards for accurate filing.

### Current Problem Information

<b>Primary Problem</b>		
<input type="text"/>		
<b>Secondary Problem</b>		
<input type="text"/>		
<b>On a scale of 1 - 10 what is your pain level?</b>	<b>Onset date of pain?</b>	<b>Cause of pain?</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Have you had this condition before?</b>	<b>Describe:</b>	<b>Prior treatment?</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please mark the areas of pain on the figures below.

