Welcome to Colorado Springs Chiropractic
Patient and Contact Information & History – RE-EXAM

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Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Name: Today's Date:

Address: City: State: Zip:

Gender: ☐ Male ☐ Female Height: Weight: DOB:

Phone: E-mail Address:

Emergency Contact Name: Phone:

Insurance: Plan Name: Subscriber ID #: Group #:

Medication List: Please list the name of each current prescribed and over the counter medications, prescribed use and any side effects/reactions.

Medication	Purpose of Taking Medication	Any Side Effects

Please initial below:

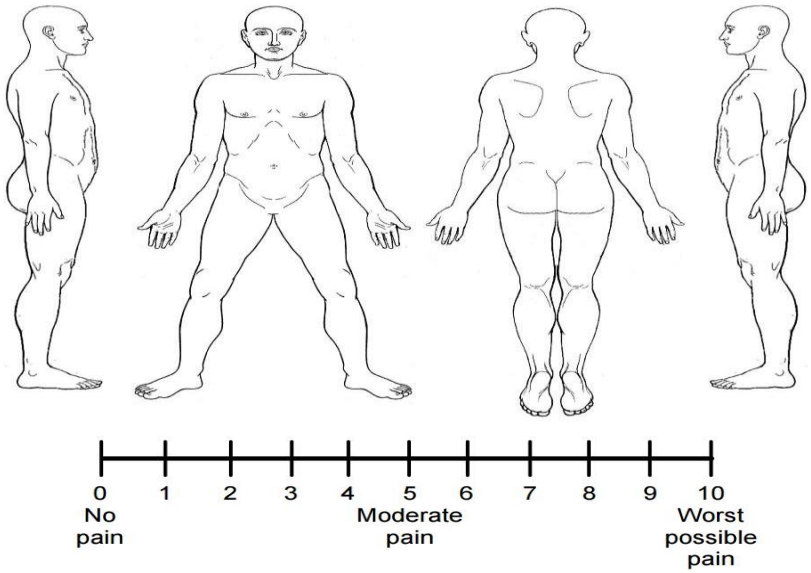
Cancellation/No Show: If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a $30 cancellation fee or $45 No Show fee.

I consent to receive text message from the practice at my number listed above. I understand that this request will apply to all future appointment reminders.

All patients are responsible for their co-pay, deductible and past due balance at time of service.

There will be a $25 service fee for any check returned for insufficient funds.

Please read carefully: Mark the areas on the diagram below that coincide with your pain. Include all the affected areas. This section can be completed in office if e-mailing form back.



Doctors Notes: