● Integrated Health ● 303 South Commercial Street Suite 10 ● Harrisburg, IL 62946 ● 618.252.5555 ●

Name:_____ **Date of Birth**:_____ **Social Security No.**:_____ **Sex**: ☐M ☐F

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

E-Mail:_____ **How referred to Office**:_____

Home Phone:_____ **Cell Phone**:_____ **Mobile Carrier**:_____ **Work Phone**:_____

Communication Preference: ☐Home Phone ☐Mobile Phone ☐Work Phone ☐Email Address ☐Mailing Address

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed Number of Children _____

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino

Race: ☐Caucasian ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Hispanic/Latino ☐Other

Employer:_____ **Phone**:_____ **Occupation**:_____

Emergency Contact:_____ **Phone**:_____ **Relationship**:_____

Family Doctor:_____ **Phone**:_____

Preferred Pharmacy: _____

Have you been seen by a ☐ **Chiropractor** Name: _____ Date: _____

☐ **Physical Therapy** Name: _____ Date: _____ Reason: _____

☐ **Acupuncture** Name: _____

Patient or Legal Guardian Signature _____ **Date** _____

Household Family Members

Name: _____ **Date of Birth**: _____

Name: _____ **Date of Birth**: _____

Name: _____ **Date of Birth**: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's Notice of Privacy Practices.
(Please Print Patient's Name or Legal Guardian's Name)

_____ _____
(Please Print Patient's Name if Minor) (Patient or Legal Guardian Signature/Relationship)

_____
(Date)

Is your illness or injury related to any of the following?

☐ Employment ☐ **Auto** **Date of Incident:** _____ **State of Incident:**_____

_____ _____ _____ _____
(Your Auto Insurance) (Phone #/Claim#) (Responsible Party) (Phone #/Claim #)

Attorney Name: _____ Phone Number: _____

For office use only: _____ insurance/DL scanned _____ patient info verified