VAN BORN CHIROPRACTIC CLINIC, P.C.

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CLINIC RE-ENTRY CARD

Date_____ Patient's Name_____ Age_____

Address_____ City/State/Zip_____

Phone No._____ Spouse's Date of Birth_____

Is your current insurance company or type of coverage different than what you had previously? ____Yes ____No

Insurance Company Name _____

Briefly Describe Chief Complaint (Symptoms) _____

_____

How and when did it happen? _____

Have you been disabled with this problem? _____

Is this a workman's comp. or auto accident injury? _____

Please List Other Symptoms (Health Problems) _____

_____

Do you ever have problems with any of the areas of your spine listed below, if so please check (even if already mentioned):

____Neck ____Upper Back ____Headaches ____Mid-Back ____Low Back (above belt) ____Low Back (below belt)

____Hip or Pelvis ____Leg Pain or Numbness ____Arm Pain or Numbness

Have you had any surgery or been hospitalized since you were last at the Van Born Chiropractic Clinic? ____Yes ____No

Have you had any accidents, fall, or injuries since you were last at the Van Born Chiropractic Clinic? ____Yes ____No

Have you had any major medical problems since you were last at the Van Born Chiropractic Clinic? ____Yes ____No

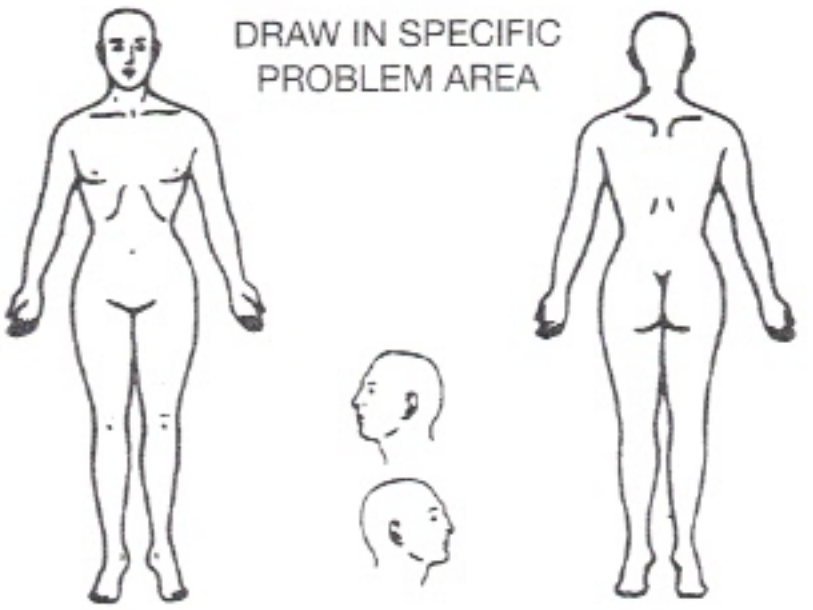
If yes to any of the above, please explain_____

____ I am interested in only symptomatic relief (feel better).

____ I am interested in symptomatic relief and maximum correction of my problem.

____ I am interested in symptomatic relief, maximum correction, and a health maintenance plan.

DRAW IN SPECIFIC PROBLEM AREA



In case of emergency, who can we call other than your home?

Name _____

Relationship _____

Address _____

City/State/Zip _____

Home Phone_____

Work Phone _____

I verify that the answers to the above questions are accurate. Signature_____

Email_____ Date_____