

Back to Health

CHIROPRACTIC

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CASE HISTORY

Name: _____ Date: _____

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

Social Security #: _____ - _____ - _____ Age: _____ Sex: _____

Birth Date: _____ # of children: _____ Marital Status: M S W D

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Spouse's name: _____ Referred by: _____

Name of Insurance Company: _____

What is your major complaint? _____

Other complaints: _____

Have you been treated by a chiropractor? yes no

If yes, how long since last treatment? _____

Seen other doctors for this condition? yes no

Are you pregnant? yes no

Are you taking any medications? yes no

If yes, which one(s): _____

List any surgeries: _____

I'm interested in: pain relief correction of my condition preventative care

Patients signature: _____ Date: _____

The patient is a minor. Permission is given by me to the doctor of this office and whomever they designate to the patient.
I am his/her legal guardian.

Guardians signature: _____ Date: _____