

# CRUZ CHIROPRACTIC & LASER THERAPY

*"Making a Difference...One Life at a Time Since 1982"*

**Please Print:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

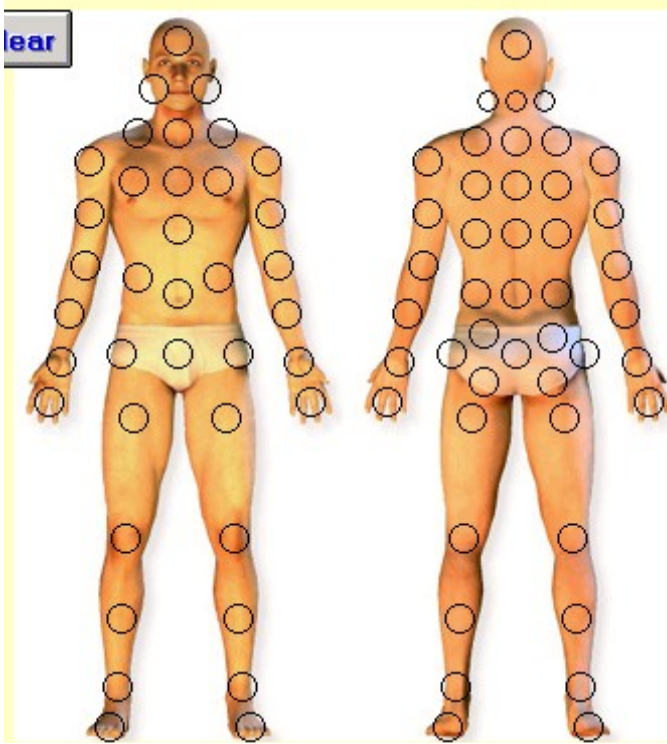
Address: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Married: \_\_\_\_, Single: \_\_\_\_, Number of Children: \_\_\_\_

Occupation: \_\_\_\_\_ Where Employed: \_\_\_\_\_

If you are in a condition involving pain, please mark the area on the body below which most likely represents your pain. If this is not a condition involving pain please write below how we can help you. \_\_\_\_\_



NO

Approximately when did this begin? \_\_\_\_\_

Please circle below at what intensity level is your pain at its worse?

**Lowest 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Highest**

Circle below what % of the day is it at the above level?

**10%- 20% -30%- 40%- 50%- 60%- 70%- 80%- 90%- 100%**

Circle below any changes since it started?

**WORSE; SAME; BETTER**

Have you seen other doctors? **YES; NO**

Have you seen a chiropractor before? **YES;**

Please circle what services you are interested in:

**Chiropractic,  
Release**

**Laser therapy,**

**Health Coaching,**

**Foot orthotics,**

**Scar Tissue**

How committed are you to your health?    **Not at all;**                      **Somewhat;**                      **Very Much**

## Payment Information

Do you have health insurance? **NO;**    **YES,** please bring your card to the receptionist to make a copy.

**PLEASE NOTE:** The cost of your exam and x-rays are to be paid on the day of service.

**(Circle)** I will be paying with: **Cash;**    **Check;**                      **Credit Card;**                      **Debit Card;**    **Care Credit**

Please let us know who referred you to our office so we can be sure to thank them.

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**Females:** Is there a chance you may be pregnant    **Yes**                      **No**

Please list all types of medications you take & for what reason.

_____	_____
_____	_____
_____	_____
_____	_____

After your first visit, you will be scheduled for a Report to discuss the different care options that are available for you. Our goal is to get you feeling better as fast as possible and give you choices for your Best Life Now!

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date