8521 North 10th Street
McAllen, TX 78504
(1 mile North of Trenton)

WholeLife CHIROPRACTIC
Dr. Orlando N. Villarreal

Office: 956.686.WELL (9355)
Fax: 956.391.2710
www.healthyRGV.com

Registration/Patient History

Patient Information

Patient Name: _____ Today's Date: _____

SSN: _____ DOB: _____ Age: _____ Sex: _____

Address: _____ City/State _____ Zip: _____

Email: _____ Employer/School _____

Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____

[ ] Married [ ] Single [ ] Separated [ ] Divorced [ ] Widowed [ ] Minor

Spouse's Name _____ Phone: ( ) _____

Whom may we thank for referring you to our office? _____

Accident Information

Is this condition due to an accident? [ ] Yes [ ] No If yes, Injury Date: _____

Type of accident: [ ] Auto [ ] Work [ ] Home [ ] Other _____

To whom have you made a report of your accident? [ ] Auto Insurance [ ] Employer [ ] Other_____

Attorney Name (if applicable) _____

Financial Agreement

Benefits quoted to us by your insurance are NOT a guarantee of payment. If your insurance pays the benefits they quoted us, the only services you will be responsible for are non-covered services, deductibles or co-pays.

I understand that I am financially responsible for all services/products rendered by WholeLife Chiropractic if not paid by my insurance company.

_____

Signature of Patient, Parent, Legal Guardian or Personal Representative Relationship to Patient

_____

Please print name of signature above Date

Patient Condition

Patient Name: _____

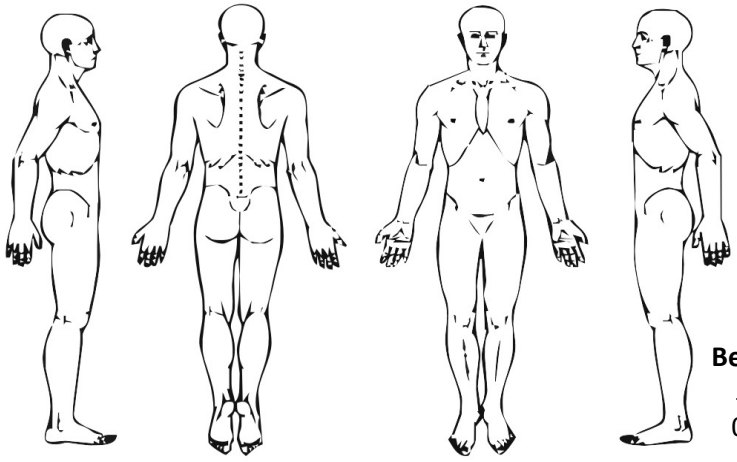
Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? [ ] Yes [ ] No

Does this condition interfere with your ability to sleep, work or play? [ ] Yes [ ] No

Please circle the area of complaints on the chart below and the types:



[ ] Sharp [ ] Dull [ ] Aching

[ ] Throbbing [ ] Burning [ ] Shooting

[ ] Swelling [ ] Stiffness [ ] Cramps

[ ] Numbness [ ] Tingling [ ] Other

Please rate your pain by circling a value below.

Best **Worst**

0 1 2 3 4 5 6 7 8 9 10

Health History

Do you smoke? [ ] Yes [ ] No If yes, how many packs per day? _____

Do you drink alcohol? [ ] Yes [ ] No If yes, how many drinks per week? _____

Exercise: [ ] None [ ] Moderate [ ] Daily [ ] Heavy

Please circle any that apply to your health history:

AIDS/HIV	Bronchitis	Glaucoma	Herniated Disk	Prosthesis
Alcoholism	Cancer	Goiter	Herpes	Psychiatric Care
Anemia	Cataracts	Gonorrhea	Headaches	Stroke
Appendicitis	Diabetes	Gout	High Cholesterol	Tuberculosis
Arthritis	Emphysema	Heart Disease	Kidney Disease	Tumors, Growths
Asthma	Epilepsy	Hepatitis	Liver Disease	Ulcers
Bleeding Disorders	Fractures	Hernia	Pacemaker	Typhoid Fever

Other: _____

Medications-Vitamins-Herbs-Supplements
