JUBILEE FAMILY CHIROPRACTIC HEALTH PROFILE

Name_____Date____/___/_____Age_____Male/Female

Address_____City_____State_____Zip_____

Phone Numbers: Home_____Cell_____

Email Address_____Date of Birth _____/_____/_____

Occupation_____Employer's Name_____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages, & Gender_____

Whom may we thank for referring you?_____

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1=mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Are symptoms constant or intermittent?
1.				
2.				
3.				
4.				
5.				

PLEASE DESCRIBE HOW YOUR HEALTH CONCERNS ARE AFFECTING YOUR LIFE_____

OTHER _____

PLEASE CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE CANCER SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

PLEASE LIST ANY ADDITIONAL INFORMATION HERE_____

_____

IF THIS HEALTH PROFILE IS FOR MINOR/CHILD, PLEASE FILL OUT & SIGN BELOW

WRITTEN CONSENT FOR A CHILD/MINOR

NAME OF PATIENT WHO IS A MINOR/CHILD_____

I AUTHORIZE DR. JUBAL MATTHEWS\ DR. MELISSA MATTHEWS AND ALL JUBILEE FAMILY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, HEALTH EVALUATIONS, AND RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZED HEALTH CARE SERVICES FOR MYB MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY JUBILEE FAMILY CHIROPRACTIC.

GUARDIAN SIGNATURE_____ DATE_____

GUARDIAN'S RELATIONSHIP TO MINOR/CHILD_____

WITNESS SIGNATURE (OFFICE STAFF) _____