



REEDCHIROPRACTIC

PREVIOUS PROVIDERS & HEALTH HISTORY FORM ❶

PATIENT NAME: _____ Date _____ Page 1 of 2

Understanding your health history is important to us. Please take the time and effort to fully and accurately provide us with the following information:

Current Family Care Provider:

Name	Address	Phone	Treatment Timeframe
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Past Family Care Provider(s):

Name	Address	Phone	Treatment Timeframe
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- 1.
- 2.
- 3.

Other Medical Providers Seen in the Past 5 Years Pre-Dating the Accident/Collision:

Name	Address	Phone	Timeframe	Reason
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- 1.
- 2.
- 3.
- 4.
- 5.

Other Medical Providers Seen any Time in Your Life Prior to the Accident/Collision for Conditions Similar to Those for Which You Currently Seek Treatment:

Name	Address	Phone	Timeframe	Reason
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- 1.
- 2.
- 3.
- 4.
- 5.



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PATIENT NAME: _____ Date _____ Page 2 of 2

Prior Automobile Accidents with Injury:

	Date	Location	Treatment Timeframe	Areas of Injury
1.				
2.				
3.				
4.				
5.				

Prior Work Related Injuries:

	Date	Location	Treatment Timeframe	Areas of Injury
1.				
2.				
3.				
4.				
5.				

Prior Slip/Fall Injuries:

	Date	Location	Treatment Timeframe	Areas of Injury
1.				
2.				
3.				
4.				
5.				

Other Injuries of Relevance:

	Date	Location	Treatment Timeframe	Areas of Injury
1.				
2.				
3.				