



**Cowan Chiropractic Clinic, PC**  
Dr. John S. Cowan; B.S., D.C.  
April Cowan, certified personal trainer  
6507 Town Center Dr., Suite F  
Clarkston, MI 48346

## Tell us about yourself

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's date: \_\_\_\_\_  
Current address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Preferred phone contact:  Home  Cell  Work How do you prefer appointment reminders?  Text  Email  Telephone  
Marital status:  Single  Divorced  Widowed  Married to: \_\_\_\_\_ (SP) Birth date: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact is your:  Spouse/partner  Parent  Other: \_\_\_\_\_  
Who can we thank for referring you to our office? \_\_\_\_\_ If you were not referred by a patient, how did you hear about our office?  Insurance company  Internet search  website  PCP/DC  drive-by  Other: \_\_\_\_\_

## Reason for your visit

What brings you into our office today/what symptoms are you experiencing: \_\_\_\_\_  
How did this happen/when did it start: \_\_\_\_\_

## Medications and allergies

Are you currently taking ANY over-the-counter or prescription medication:  No  Yes - please list name, dosage, frequency & condition  
*Remember to list ALL drugs including aspirin, antibiotics, insulin, birthcontrol pills, blood pressure pills, etc.*

Drug	Condition	Drug	Condition
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications:  No  Yes - please indicate which medications and your reaction: \_\_\_\_\_  
Do you have any environmental allergies:  No  Yes - please indicate to what and your reaction: \_\_\_\_\_

## Other health care providers

Have you ever been to a doctor of chiropractic before?  No  Yes - How long ago? \_\_\_\_\_  
Name of previous chiropractor: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Do you have a primary care physician?  No  Yes - date of last visit: \_\_\_\_\_  
Name of PCP: \_\_\_\_\_ Type:  MD  DO  Naturopath Phone #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be detrimental to my health. I hereby acknowledge that I am receiving (or about to receive) health care services as Cowan Chiropractic Clinic and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance (third party payor) or out of the settlement of a liability case. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. It is my responsibility to inform Cowan Chiropractic Clinic of any changes in my health status and or financial status.

Dated the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Parent (if minor child)