Confidential Client Information

Please Print Clearly:

Name:____ Date:___________________

Address:____

Primary Telephone #:_____________________Occupation:_______________________

Date of Birth:___________ Age:______ Sex:______ Height:_______ Weight:________

Emergency Contact Name:______________________ Telephone:__________________

Marital Status:______ Pregnant?_______E-mail:________________________________

Referred by:____

Current Complaints:____

Date of Injury / Onset:___________ How did this start:__________________________

____

Other Involved Health Care Providers:____

I acknowledge that Dr. Malakoff has explained/disclosed the benefits and risks associated with chiropractic treatment and understand that my confidential medical records will be treated in accordance to the standards and practices of the HIPPA codes. I hereby authorize Dr. Malakoff to treat my condition, as he deems appropriate.

Signature: ____Date:______________

Gregory S. Malakoff, D.C.