Confidential Client Information

Please Print Large and Clearly so that I can read it. Thanks:

Name:_____ Date:_____

Address:_____City_____Zip_____

Email:_____

Primary Telephone #:_____Occupation:_____

Date of Birth:_____ Age:_____ Sex:_____ Height:_____ Weight:_____

Emergency Contact Name:_____ Telephone:_____

Pregnant?_____ Referred by:_____

Current Complaints:_____

Date of Injury / Onset:_____

Do you have a history of epilepsy, seizures, strokes, vertigo? Yes___ No___

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. Dr. Malakoff has explained that the goal of today's treatment is to provide relief and if adequate results are not obtained in a clinically reasonable amount of time that diagnostic imaging and other tests may be necessary.

Signature: _____Date:_____

Gregory S. Malakoff, D.C.
www.atyourbackandcall.com