

HORNBERGER WELLNESS & CHIROPRACTIC
Joseph P. Hornberger, M.S.,D.C. P.A.

Patient name: _____

Date: _____

(List the Doctor(s) You Have Seen Previously for This Injury in Order of Occurrence)

NONE:

Doctor #1

Address _____

Treatment Received _____ How Long Treated _____

What Were the Results _____

Were You Referred to Another Doctor: Yes _____ No _____

Who Were You Referred to _____

Doctor #2

Address _____

Treatment Received _____ How Long Treated _____

What Were the Results _____

Were You Referred to another Doctor: Yes _____ No _____

Who Were You Referred to _____

Doctor #3

Address _____

Treatment Received _____ How Long Treated _____

What Were the Results _____

Were You Referred to Another Doctor: Yes _____ No _____

Who Were You Referred to _____

List Any and All Prior Injuries or Accidents (Auto, Work Related, or any other)

NONE:

1. Type of Injury _____

Date It Occurred _____ Resulting Injuries _____

2. Type of Injury _____

Date It Occurred _____ Resulting Injuries _____

3. Type of Injury _____

Date It Occurred _____ Resulting Injuries _____

NOTES: Dr. Initials: