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:

_____

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