**Integrated Health, S.C.**
**1 South Virginia Street. – Crystal Lake, IL – 60014**
**815/356-9371; fax: 815/356-9428**

**Please provide us with the following personal and other pertinent information requested. Please print clearly.**

Name: ______________________ Date: ______________________

Nickname preferred: ______________________ Gender: ❑ Male ❑ Female

Address: ______________________

City: ______________________ State: __________ Zip: __________

Home Phone #: ______________________ Work Phone #: ______________________

Social Security #: ______________________ Date of Birth: ______________________

E-mail address: ______________________

Were you referred by: ❑ Family ❑ Friend ❑ Insurance Carrier ❑ Physician ❑ Other

Name of person who referred you: ______________________ Phone #: __________

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Company Name: ______________________ Occupation: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

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Spouse's Name: ______________________ Date of Birth: ______________________

Social Security #: ______________________ Occupation: ______________________

Employer Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

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**Please list any and all insurance and/or employee health care plan coverage you or your spouse may have:**

Insurance Co. or Health Care Plan name: ______________________

Policy/Group#: ______________________ Effective Date: ______________________

Name of insured: ______________________

**Please list any and all insurance and/or employee health care plan coverage you or your spouse may have:**

Insurance Co. or Health Care Plan name: ______________________

Policy/Group#: ______________________ Effective Date: ______________________

Name of insured: ______________________

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Are your present symptoms or conditions related to or be the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ❑ Yes ❑ No

*If you answered yes, please fill out an accident specific form, available at our office.*

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Family Physician: ______________________
Person to contact in an emergency (name and phone #): ______________________
Attorney: ______________________ Phone #: ______________________
Address: ______________________