CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:
In order to expedite your visit you may print the below patient case history forms, and complete them before you come to the office. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.
Thank You.

Name:			Social Security #:
Address:			
City:	State:	Zip:	
Home Phone:	Work Phone:	Cell Phone:	
Date of Birth:	Age:	Marital Status: **M S W D** (Circle One)	# of Children:
Spouse's Name:			Occupation:
Spouse's Work Phone:		Referred by:	

HEALTH INFORMATION

Have you had previous chiropractic care?:

What is your Major Complaint?:

Other Complaints?:

How long have you had this condition ?:

Have you had this or similar conditiona in the past ?:

What Activities Aggravate your condition?:

Is this condition getting progressively worse ?: ☐YES ☐NO ☐Constant ☐Comes & Goes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily Routine ☐Other _____

How long has it been since you really felt good?:

Other doctors who have treated this condition?:

List Surgical Operations and the Year they happened?:

Drugs that you now take:
___ Nerve Pills ___ Pain Killers ___ Muscle Relaxer ___ "Pep" Pills ___ Tranquilizers ___ Insulin ___ Birth Control Pills
Others _____

Age of Mattress _____ Years _____ Comfortable _____ Uncomfortable

Are you wearing: ____Heel lifts ____Sole lifts ____Inner soles ____Arch supports

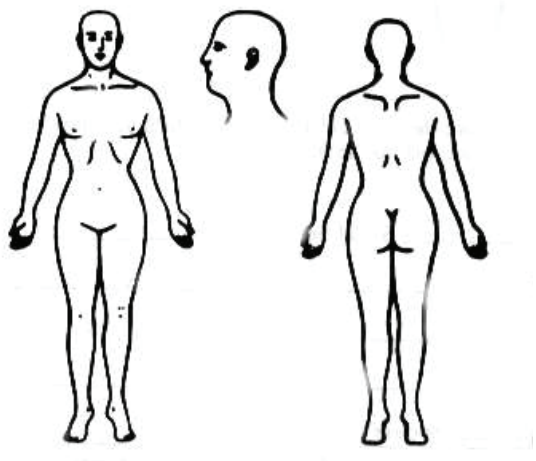
Have you been in an auto accident? ____Past year ____Past 5 years ____Over 5 years ____Never
Describe :

Have you been in an auto accident? ____Past year ____Past 5 years ____Over 5 years ____Never
Describe:

Have you had any other personal injury or accident? ___Past year ___Past 5 years ___Over 5 years ____None
Describe:

Date of Last Physical Examination:

Please mark your areas of pain on the figures below



Have you ever suffered from:
Dizziness _____
Backaches _____
Heart Trouble _____
Diabetes _____
Arthritis _____
Headaches _____
Asthma _____
Neuritis _____
Digestive Disorders _____
Nervousness _____
Sinus Trouble _____
Neck Pain _____

Insurance Information

Is your condition due to an auto accident or job related injury? ____YES ____NO
Do you have Health Insurance: ___YES ___NO
If yes, Name of Company _____ Policy #_____
Are you covered by Medicare? ___YES ___NO
If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports or forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate may care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature_____ DATE_____

Guardian or Spouse's Signature:_____

Doctor's Signature:_____

FAMILY HEALTH INFORMATION:

Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.
Is there any history of Caner in your Family ? _____
Have there been any injections from a MD or Dentist within the Last Year?: YES _____ NO _____

Name	Relation	Present Heath Problems