CONFIDENTIAL CASE HISTORY

Dear Patient:

Please complete all questions. Please be as thorough as possible. Please print.
THANK YOU

Name ______________________________ Social Security #____________________

Address ____________________ City ______________ State _______ Zip______

Home Telephone ______________Occupation ______________________________

Work Telephone ____________________Age ____ Date of Birth ______ Cell #________

Fax # ______________________ *E-mail address (for our newsletter)________________

Children _____ Ages of Children _________ Nearest Relative's home phone______________

Spouse's Name________ Spouse's Office Telephone _______________ Marital Status: M S W D

How were you referred to our office? ______________________________________
Have you had previous chiropractic care? If yes, how long ago and how often?____________________________________

IF APPLICABLE, WHAT IS YOUR COMPLAINT(S) AND HOW LONG HAVE YOU HAD IT (THEM)?____

Have you had this or similar condition(s) in the past? ________________________

What activities aggravate your condition? ______________________________

Is this condition getting progressively worse? ( ) Yes No ( ) Is it: ( ) Constant ( ) Comes and 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 treated this condition ______________________________

***Who is your:**

Medical Doctor ______________ Podiatrist______________________

Dentist _________________ Pediatrician (for children only)_____________

Surgeries and operations, please list year:
____

OVER PLEASE

Drugs you now take: ( ) Pain killers (including over the counter) ( ) Muscle relaxants ( ) "Pep" pills ( ) Tranquilizers ( ) Insulin ( ) Birth control pills ( ) Other ________________________________

If you know the drug name, please list and include dosage

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Date of Last Physical Examination ____
Have you ever been in a car accident (even minor fender-benders) ? ( ) Yes ( ) No, If Yes, give date(s) and describe:

____

Have you had any other personal injury or accidents? (e.g. slip and fall) ? ( ) Yes ( )No, If Yes, give date(s) and describe:

____

Have you ever suffered from or have been diagnosed in the past or present with:

☐ **Dizziness** ☐ **Headaches** ☐ **Shortness of Breath** ☐ **Asthma/Allergies** ☐ **Chest Pain** ☐ **Digestive Problems**
☐ **Heart Trouble** ☐ **Sinus Problems** ☐ **Diabetes** ☐ **Skin Problems** ☐ **Cancer** ☐ **Backache** ☐**Other**____________

Family Health History:

MANY HEALTH PROBLEMS ARE THE RESULT OF HEREDITARY SPINAL WEAKNESSES AND NOT NECESSARILY ACCOMPANIED BY PAIN OR SYMPTOMS; THUS INFORMATION ABOUT YOUR FAMILY MEMBERS WILL GIVE US A BETTER PICTURE OF YOUR TOTAL HEALTH.

Name: **Relation:** **Past and Present Health Problems: write in margin, if necessary**

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INSURANCE INFORMATION:

Is your condition due to an auto accident or work related injury? ( )Yes ( )No
Do you have Health Insurance? ( )Yes ( ) No
If Yes, Name of Insurance Company ________________________________ Policy #:______________________
Address ____ Phone #: __________________________

If you have no insurance, would you be interested in an affordable plan to enable you to receive care in this office? ( ) Yes ( ) No

PLEASE READ:

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 and 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 upon receipt. However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend care, any fees for professional services rendered to me will be immediately due and payable.

I will be paying today by: ( ) Cash ( ) Check ( ) Credit Card # ________________________ exp. date ________

Patients signature: ____ Date:__________________________
Guardians signature (if minor): ________________________________ Date: __________________________