CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. 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 Telephone _____ Work Telephone _____ **Cellular Phone** _____

Age _____ Birthdate _____ # Children _____

Marital Status: M S W D Employer: _____ Occupation _____

EMAIL _____ Spouse's Name & Tel: _____

Referred by _____ Nearest Relative & Telephone _____

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 conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ 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 _____

_____

List surgical operations and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers
☐ Insulin ☐ Birth control pills ☐ Others _____

Age of mattress _____ ☐ 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

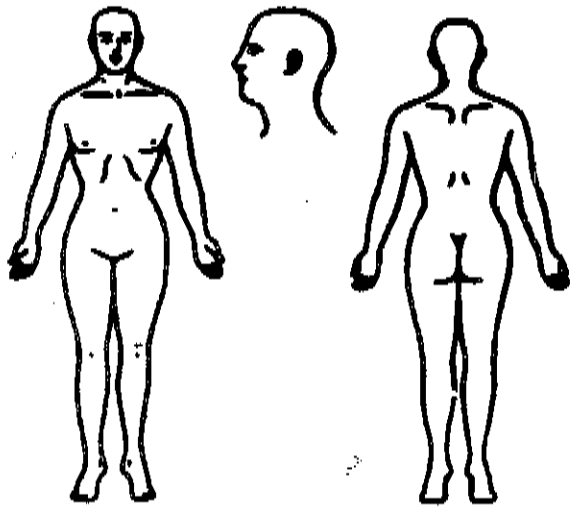
Describe: _____

Have you 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:

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____Yes _____No
If, yes Auto_____ or Job Related _____

Do you have Health Insurance? _____ Yes _____No If yes,

Name of Company _____

Are you covered by Medicare? _____ Yes _____ No

If yes, Health Insurance # _____

I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo treatment and I hereby give my consent for treatment.

Patient's Signature _____

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 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 my 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: _____ S.S. # _____

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.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS