



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 conditions will respond satisfactorily, we will not accept your case. Thank you.

Name _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D
Work Telephone _____ Email: _____
Spouse's Name _____ Spouse's Work Telephone _____
Occupation _____ # Children _____ Referred by _____
Employer _____ Employer Address _____

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 conditions? _____

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 [] Other _____

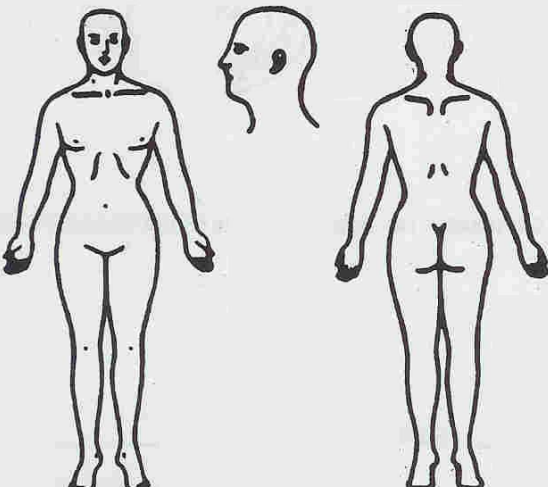
Age of mattress: _____ [] Comfortable [] Uncomfortable

Are you using: [] Heal lifts [] Sole lifts [] Inner Soles [] Arch Supports

Have you been in an auto accident? [] Past year [] Past 5 years [] Over 5 years [] Never

Describe any injuries and pain as a result of any auto accident: _____

Date of last physical examination: _____

<p style="text-align: center;"><i>Please mark your areas of pain on the figures below.</i></p> 	<p>Have you ever suffered from:</p> <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> <tr> <td>1. Dizziness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>2. Backaches</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>3. Heart Trouble</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>4. Diabetes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>5. Arthritis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>6. Headaches</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>7. Asthma</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>8. Neuritis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>9. Digestive Disorders</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>10. Nervousness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>11. Sinus Trouble</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>12. Neck Pain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Yes	No	1. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	2. Backaches	<input type="checkbox"/>	<input type="checkbox"/>	3. Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	5. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	6. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	7. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	8. Neuritis	<input type="checkbox"/>	<input type="checkbox"/>	9. Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>	10. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	11. Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	12. Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
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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

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 Insurance: _____ Policy # _____

Are you covered by Medicare: Yes No Policy # _____

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 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable. If my account goes more than 30 days delinquent, a service charge of 1 1/2 % per month, 18% APR, will be added to all overdue accounts. I will be liable for all legal and collection fees in addition to the interest incurred.

Patients Signature: _____

Guardian or Spouse's Signature: _____

Date: _____

Doctor's Signature: _____