FAMILY WELLNESS CENTER
A DIVISION OF FAMILY CHIROPRACTIC, LTD.

CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION DATE _____

Name _____ Social Security _____----_____----_____
Home Phone _____ Cell Phone _____ Email _____
Address _____ City _____ Zip Code _____
Age _____ Birth Date _____ Marital: **M S W D** How Many Children? _____
Occupation _____ Employer _____ Office Phone _____
Address _____
Name of Spouse _____ Occupation _____
Employer _____ Address _____
Name of Nearest Relative _____Address _____ Phone _____
Referred By _____
Is the condition due to injury or sickness arising out of employment ? _____
Is the condition due to injury or sickness arising out of auto or other accident? _____
Days lost from work? _____ Date symptoms appeared or accident happened _____
Have you ever had the same or a similar condition: Yes ____ No ____
If yes, when and describe_____

Date of last physical examination _____
What operations have you had? _____ When? _____
Serious Illnesses _____ When ? _____
Have you ever suffered from:

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Tuberculosis _____
6. Arthritis _____
7. Headaches _____
8. Numbness _____
9. Asthma _____
10. Neuritis _____
11. Digestive Disorders _____
12. Nervousness _____
13. Sinus Trouble _____
14. Anemia _____
15. Rheumatic Fever _____
16. Cancer _____

Purpose of this appointment _____
Other doctors seen for this condition _____
Have you been treated for any health condition by a physician in the last year? YES ( ) NO ( )
Describe _____
What medications or drugs are you currently taking? If needed please use attached medication list._____

I understand and agree that health and accident insurance policies are an agreement between my insurance company and myself ~ Not between my insurance company and this office. I request the chiropractic clinic to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE: YES ( ) NO ( ) COMPANY : _____
Patient Signature _____ Date _____
Guardian's Signature Authorizing Care _____ Date_____