CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION DATE ____________________

Name ____________________________________ Birth Date __________________ Age _________
Cell Phone ____________________ Home Phone _________________ Email ___________________
Address _________________________________ City ___________________ Zip Code ___________
Gender: **Male Female Prefer not to answer** Marital Status: **M S W D** How Many Children? _______
Occupation ____________________ Employer _____________________ Office Phone ____________
Address ____
Name of Spouse _______________________ Occupation __________________________________
Employer __________________________ Address ____________________________________
Emergency Contact ______________________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 and dates? ____
____
Serious Illnesses and dates? ____
Have you ever suffered from:

1. Dizziness _____________	6. Arthritis _____________	11. Digestive Disorders _______
2. Backaches ____________	7. Headaches ___________	12. Nervousness ____________
3. Heart Trouble _________	8. Numbness ___________	13. Sinus Trouble ___________
4. Diabetes _____________	9. Asthma ______________	14. Anemia ________________
5. Tuberculosis __________	10. Neuritis ____________	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 _________________