

# 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 \_\_\_\_\_

Email Address \_\_\_\_\_ Fax # \_\_\_\_\_ Pager \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ # Children \_\_\_\_\_

Marital Status: M S W D Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Office Telephone \_\_\_\_\_

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 you: 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

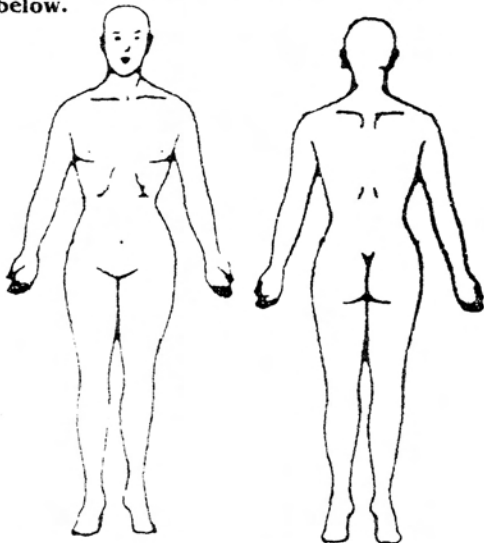
Describe: \_\_\_\_\_

Have you had any other personal injury or accident?  Past year  Past 5 years  Over 5 years

None

Describe: \_\_\_\_\_

Please mark your areas of pain on the figure 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

Do you have Health Insurance? Yes  No

If Yes, Name of Company? \_\_\_\_\_ Policy# \_\_\_\_\_

Are you covered by Medicare? Yes  No

If Yes, Health Insurance # \_\_\_\_\_

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 an 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.

I will be paying today by  Cash  Check  Credit Card

Mastercard  Visa  American Express Card# \_\_\_\_\_ Exp Date \_\_\_\_\_

All accounts not paid within 90 days will automatically be put through on your credit card.

Patients Signature: \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_ S.S.# \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

**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