

**CONFIDENTIAL PATIENT CASE HISTORY**

Dear patients: 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 \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Martial Status: M D S W P # of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Referred By \_\_\_\_\_ Emergency Phone # \_\_\_\_\_

**HEALTH INFORMATION:** Have you had previous Chiropractic Care? Y N Most Recent \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Other Complaints \_\_\_\_\_

Onset of Complaints/condition \_\_\_\_\_

How long have you had this condition \_\_\_\_\_ Have you had this conditions in the past? Y N

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 \_\_\_\_\_

Do other family members have similar problems? Yes  No

Please list \_\_\_\_\_

Other doctors treated this condition? \_\_\_\_\_

List surgical operations and years \_\_\_\_\_

Drugs you currently taking \_\_\_\_\_

Are you wearing foot/arch supports/heel lifts? Y N Age of your mattress? \_\_\_\_\_

Have you been in an auto accident? Y N Past year  Past 5 years  Over 5 years  Never

Describe \_\_\_\_\_

Have you had any other personal injury, job related injury or accident?  
Past year  past 5 years  over 5 years  none

Describe \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

**HAVE YOU EVER SUFFERED FROM:**

Dizziness \_\_\_\_\_  
Backaches \_\_\_\_\_  
Heart trouble \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Headaches \_\_\_\_\_  
Asthma \_\_\_\_\_  
Digestive Disorders \_\_\_\_\_  
Nervousness \_\_\_\_\_  
Sinus Trouble \_\_\_\_\_  
Neck pain \_\_\_\_\_

**FAMILY HEALTH INFORMATION** (many health problems are the result of hereditary spinal weaknesses; thus information about your family members will provide us with valuable information to serve you better:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INSURANCE INFORMATION**

Is your condition due to an auto accident or job related injury? Yes  No

Do you have health insurance? Yes  No

Name of company: \_\_\_\_\_ Policy: \_\_\_\_\_

Are you covered by Medicare: Yes  No

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 to 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 pay today by  cash  check  credit card

Patient's signature \_\_\_\_\_ date \_\_\_\_\_

Guardian or spouse's signature \_\_\_\_\_ S.S# \_\_\_\_\_

Doctor's signature \_\_\_\_\_