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 ____________ Cell#: ________

Age ____________ Birthdate ______________ # Children ____________

Marital Status: M S W D Employer ______________________________

Occupation ____

Spouse's Name ____________________ Spouse's Office Telephone __________

Referred by ____________________ Nearest Relative & Telephone __________

Health Information: Have you had previous chiropractic care? __________

What is the purpose of this appointment? ______________________________

____

Other complaints: ____

Onset of complaints/condition: ____

How long have you had this condition?____ Have you had this or similar 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 your: Work ( ) Sleep ( ) Daily Routine ( ) Other ________

Do other family members have similar problems? Yes ( ) No ( )

Please list ____

Other doctors who treated this condition ___________________________________

____

List surgical operations and years: ______________________________________

____

Date of last physical exam ____

Drugs you now take: ( ) Nerve pills ( ) Pain killers ( ) Muscle Relaxers

( ) "Pep" pills ( ) Tranquilizers ( ) Insulin ( ) Birth control

( ) 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

Have you had any other personal injury, job related injury or accident? ( ) Past year ( ) Past 5 years ( ) Over 5 years ( ) None

Describe ____

YES OR NO:

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 ____________
13. Tuberculosis ____________
14. Cancer ____________

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 # ______________________________

Payment is expected at time of visit.

Name of person responsible for payment ______________________

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 be paying today by ( ) Cash ( ) Check ( ) Credit Card

( ) Master Card ( ) Visa ( ) American Express Card # ______________________ Exp. Date ______

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

Patient's Signature: ______________________________ Date ______________

Guardian or Spouse's Signature: ______________________________ S.S. # ______________