

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' 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: _____

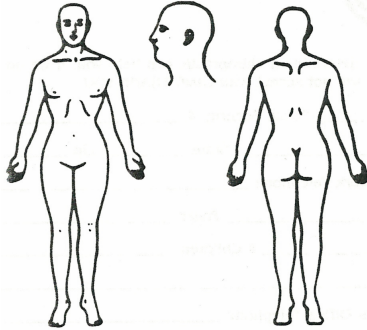
Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None

Describe: _____

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Date of Last Physical Examination _____

Please mark your areas of pain on the figures 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 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 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.

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature _____

Doctor's Signature _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of heredity spinal weaknesses: thus information about your family members give us a better picture of your total health picture.)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS