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 _____

Age _____ Birth date _____ # Children _____

Marital Status (Circle one) 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 _____

Onset of complaints/condition _____

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 your Work ❑ Sleep ❑ Daily Routine ❑ Other _____

Do other family members have similar problems? Yes ❑ No ❑

If yes, please list _____

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 _____

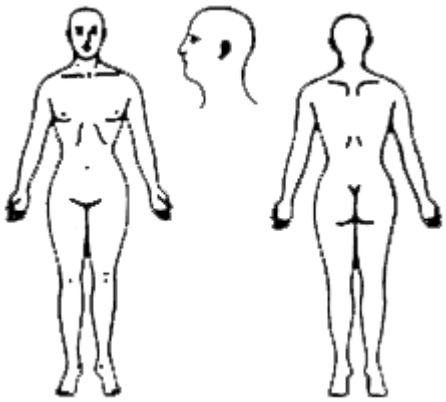
Have you had any other personal injury, job related injury or accident?

Past year ❑ Past 5 years ❑ Over 5 years ❑ None ❑

Describe _____

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 Insurance 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 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 ❑

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 _____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***