



Case History

NAME _____
(Last) (First) (M.I.)

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____ E-MAIL _____

DATE OF BIRTH _____ MARRIED _____ SINGLE _____ NUMBER OF CHILDREN _____

EMPLOYED BY _____ BUSINESS PHONE _____

SPOUSE _____ EMPLOYED BY _____

REFERRED BY _____ SOCIAL SECURITY # _____

CHIROPRACTIC CARE IN YOUR PAST? _____ WHERE? _____ WHEN? _____

ACUPUNCTURE IN YOUR PAST? _____ WHERE? _____ WHEN? _____

HEALTH INSURANCE? _____ INSURANCE COMPANY _____

SUBSCRIBER ON CARD _____

POLICY & GROUP # _____

BIRTHDATE OF INSURED _____

DATE OF ACCIDENT/INJURY/ONSET OF ILLNESS _____ / _____ / _____

RELATIONSHIP TO PATIENT: 1. SELF _____ 2. SPOUSE _____ 3. CHILD _____ 4. OTHER _____

____ INSURANCE PATIENT: Insurance is a contract between the insured (patient) and the insurance company. This office does not accept assignment for the insurance benefits. We will, however, supply the insured with all necessary information needed to submit claims easily and quickly. If payment is not made the day services are rendered, a \$2.00 billing charge will be applied to your account. Additionally, we will be happy to submit the claim for a \$2.00 service charge, but the responsibility for payment of services rendered remains with the patient.

____ PERSONAL INJURY: If you have coverage, upon verification, it will be accepted. In such a case, this office will accept assignment for the insurance benefits with the understanding that the patient remains fully obligated for the liabilities of services rendered if applicable insurance will not cover such charges. Your insurance will be billed directly.

____ WORKMAN'S COMPENSATION: We ask you to bring written verification from your employer for treatment. Without such verification of injury, you will be responsible for fees.

____ MEDICARE: This office does not file Medicare paperwork. Services rendered at this office are not billable or reimbursable by medicare.

Major Complaint _____

Stress/Emotional Complaint _____

Have you had this condition in the past? _____

Date you first noticed symptoms? _____

Other Doctors you have seen for this condition? _____

Major Illness _____

Accidents, Falls, Etc. _____

Hospitalizations _____

Surgeries _____

(turn page over)



Current Medications _____
 Current Nutritional Supplements _____
 Amount of water per day? _____ Soda? _____ Coffee? _____
 Smoke Cigarettes? _____ How much? _____ Last Physical Exam _____
 Do you Exercise Regularly? _____ How often? _____ What? _____

PLEASE CHECK THE SPACE FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD PREVIOUSLY. THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL

_____ Allergy (list) _____

 _____ Asthma
 _____ Convulsions/Seizures
 _____ Dizziness
 _____ Fainting
 _____ Headache
 _____ Migraine Tension
 _____ Numbness

MUSCLE & JOINT

_____ Arthritis
 _____ Low Back Pain (1-10) _____
 _____ Neck Pain (1-10) _____
 _____ Pain between shoulders
 _____ Scoliosis

PAIN OR NUMBNESS IN:

_____ Shoulder _____ Arms
 _____ Elbows _____ Hands
 _____ Hips _____ Legs
 _____ Knees _____ Feet

Please rate (1-10)

GASTRO-INTESTINAL

_____ Constipation
 _____ Diarrhea
 _____ Difficult digestion
 _____ Gall Bladder problems

EYES/EARS/NOSE & THROAT

_____ Frequent colds
 _____ Earache
 _____ Ear noises/ringing
 _____ Nasal obstruction
 _____ Nosebleeds

CARDIO-VASCULAR

_____ Abnormal heart beat
 _____ High blood pressure
 _____ Low blood pressure
 _____ Poor circulation
 _____ Swelling of extremities

RESPIRATORY

_____ Chest pain
 _____ Chronic cough
 _____ Difficult breathing

URINARY

_____ Bed-Wetting
 _____ Frequent urination
 _____ Kidney infection
 _____ Kidney stones
 _____ Prostate trouble

FOR WOMEN ONLY

_____ Cramps/Backache
 _____ Irregular cycle
 _____ Perimenopause
 _____ Sinus infection
 _____ Menopause

SKIN

_____ Bruise easily
 _____ Dryness
 _____ Rash
 _____ Varicose vein

IMMUNIZATIONS

_____ Flu _____ Polio
 _____ DPT _____ MMR
 Any adverse reaction to vaccine?

WOMEN ONLY

I _____ HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT.

SIGNATURE _____ DATE _____

I hereby give permission to the doctor to administer treatment and perform such general procedures as she/he may deem necessary in the diagnosis and/or treatment of my condition.

I understand fees are payable when services are received, should any legal action be necessary in order to collect fee, all costs associated with the collection and attorney fees shall be payable by the patient.

SIGNATURE _____ DATE _____

(please check if applicable)

_____ AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process my claim(s) for reimbursement of charges incurred by me as a result of professional services by you and I hereby release you of any consequences thereof.

_____ AUTHORIZATION TO PAY DIRECTLY TO DOCTOR: In consideration of the chiropractic services rendered and to be rendered by her, I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe her by my attorney, out of the proceeds of any settlement of my case and/or by any insurance company obligated to reimburse me for the charges for services rendered.

APPROVAL SIGNATURE _____

