Patient Case History

No. _____ Date _____

Patient's Information

Patient: _____ Date of Birth: _____ Marital Status: M S W D

Address: _____ City: _____ State: _____ Zip: _____

SS No.: _____ Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____ Address: _____

Name of Spouse: _____ SS No.: _____ Work Phone: _____

Occupation: _____ Employer: _____ Address: _____

Nearest relative not living with you? _____ Phone: _____

Who referred you to our practice? _____

Patient's Insurance

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone No.: _____

Spouse's Insurance

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone No.: _____

Who is responsible for payment? ❑ Self ❑ Spouse ❑ Other

Additional Information

List in order of importance - your current symptoms or current activity restrictions:

1. _____ ❑ Causes pain ❑ Unable to perform
2. _____ ❑ Causes pain ❑ Unable to perform
3. _____ ❑ Causes pain ❑ Unable to perform
4. _____ ❑ Causes pain ❑ Unable to perform

Date of illness or onset: _____ Time: _____ ❑ AM ❑ PM Location: _____

Related to accident? ❑ Auto ❑ On the job ❑ Other _____

List any other Doctors seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? ❑ Yes ❑ No

If yes, explain: _____

Assignment and Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necesary 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 to me will be immediately due and payable.

Physician's Signature: _____ Patient's Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____

Parent's or Guardian's Signature: _____

Over Please

HEALTH QUESTIONNAIRE

PLEASE CHECK (√) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

MUSCULO-SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Muscle spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

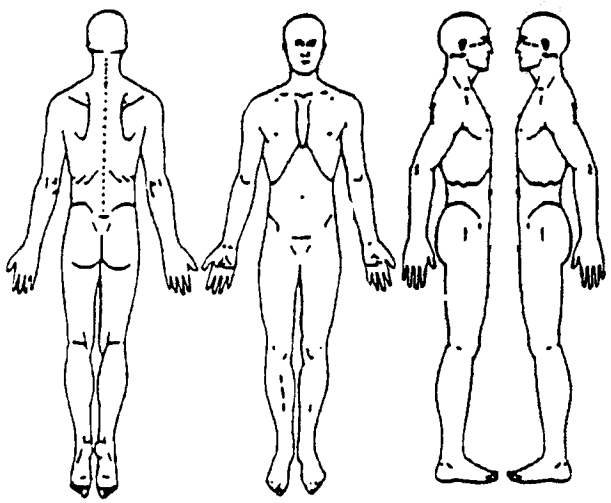
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

Please mark areas of pain on the figures below



P ___ Pain
N ___ Numb
H ___ Hypoesthesia
S ___ Spasm

Pain Index
Least 1 2 3 4 5 6 7 8 9 10 Most

GASTRO-INTESTINAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confus ion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Excercise
- ❑ Drug Abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistant cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose viens

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

Patient's Signature _____

FOR OFFICE USE

_____

_____

_____

_____

Patient Accepted? ❑ Yes ❑ No Doctor's Signature _____