Rebalance Restore Revitalize

Case History

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

ADDRESS _____ PHONE _____

CITY_____ STATE _____ ZIP_____ E-MAIL _____

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

EMPLOYED BY _____ CELL 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 reimbursaable 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 reaceived, 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 _____

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