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 ____________________

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.

____ 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.

____ A minimum $3 service charge will be added to all credit card/debit charges up to $100. $5 up to $500 and 5% over $500.

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
_______ Elbows
_______ Hips
_______ Knees
_______ Arms
_______ Hands
_______ Legs
_______ 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
_______ Covid

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
_______ Covid Vaccine
_______ Date __________ Type
_______ Covid Booster
_______ Date __________ Type

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 ______________________________