Case History

Name:_____ DOB:_____Age:_____Date:_____
Address:_____City:_____State:_____Zip_____
Phone:_____(H/C/W) Email_____
Sex: Male/Female Marital Status: Single/Married/Divorced/Widowed #Children:___
Insured's Name:_____ Policy Number_____
Name of Provider_____ Relationship to insured_____
Co-pay?_____ Deductible?_____ Has Deductible been met?_____

Are your current complaints due to an injury/accident? Yes/No Type:_____
Has the accident been reported?_____ Are you or have you been disabled?_____
Have you retained an attorney? Yes/No Name of Attorney:_____

Current Complaint/Symptoms – Please list in order of Severity – highest on top.
If 0 is no pain and 10 is take me to the hospital – how would you rate the pain of each?
1._____Rate_____ Began:_____ Previous Issue? Y/N
2._____Rate_____ Began:_____ Previous Issue? Y/N
3._____Rate_____ Began:_____ Previous Issue? Y/N
4._____Rate_____ Began:_____ Previous Issue? Y/N
5._____Rate_____ Began:_____ Previous Issue? Y/N

Do you use tobacco? Yes/No Amount/Day:_____ Smoke/Chew (Circle)
Do you drink alcohol? Yes/No Amount/Week:_____
Do you drink caffeine? Yes/No Amount/Day: _____
How much exercise to do you get on an average week? None, Some, Moderate, Heavy?

Please mark the applicable box if there is a family history of the following?

Mother	Diabetes____	Heart_____	Kidney_____	Cancer _____	Other_____
Father	Diabetes____	Heart_____	Kidney_____	Cancer _____	Other_____
Brother #___	Diabetes____	Heart_____	Kidney_____	Cancer _____	Other_____
Sister #___	Diabetes____	Heart_____	Kidney_____	Cancer _____	Other_____
You	Diabetes____	Heart_____	Kidney_____	Cancer _____	Other_____

Have you had any of the following Operations or Procedures? Mark/Date all that apply.

Date		Date		Date	
_____	Back	_____	Neck	_____	Tubes in ears

_____ Organs (Appendix, Gallbladder, Female, Stomach, Prostate – Circle)
_____ Repairs (Hernia, Hemorrhoids) _____ Other

Please list any accidents or falls and their dates:
Car:_____ Sports:_____ School:_____
Work:_____ Recreation:_____ Other:_____
Have you had any broken bones:_____
Have you ever been on crutches?_____ Why_____
Have you ever had x-rays taken?_____ Why_____
Have you ever been to a Chiropractor? Yes/No If Yes Who?_____
Is there any other problem that brings you to the office today?_____
Are you on any medications? Prescription, Vitamin, Herbs, or Over the Counter? Y/N
Please list:_____

Please mark all of the following that you ***currently*** have.

Allergies___ to what_____

Bronchitis_____ Chills____ Fever_____ Asthma_____ Wheezing___
Headache_____ Fatigue_____ Weight Loss_____ Weight Gain____
Depression_____ Numbness___ Where?_____ Fainting____ Sweats____

Backache_____ Neck Pain_____ Pain between shoulder blades_____
Foot Pain_____R/L Knee Pain_____ R/L Ankle Pain_____R/L
Hip Pain_____R/L Groin Pain_____ R/L
Hand Pain_____R/L Wrist Pain_____R/L Elbow pain_____R/L
Shoulder Pain_____R/L

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The doctors' office will prepare and file my claim with the insurance company for me and any direct payments to the doctor will be credited to my account. If there is any balance due it is my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the doctors' office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine me for the treatment of my condition as deemed appropriate through the use of Chiropractic Health Care. With my signature below I give permission for these procedures to be performed. When I pay for X-ray examinations this is for the examination only; the negative will remain the property of the doctors' office and on file at that office as long as I am a patient.

I am the responsible party for payment for any treatment received or costs incurred on this account. This doctor is not responsible for any pre-existing medical condition that has been diagnosed or is being treated by another doctor(s).

Patient or Guardians' Signature: _____ Date:_____

Patient or Guardians' Printed name:_____