

# Confidential case history

Dear Patient,

Date \_\_\_\_\_

**Please complete this questionnaire. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.**

**THANK YOU**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

How do you wish to be addressed in this office? First name \_\_\_\_\_ or Mr. Mrs. Ms. Miss Dr

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Cell Carrier \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital Status: M S W D **Referred by** \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

Occupation \_\_\_\_\_ Hobbies: What occupies your spare time? \_\_\_\_\_

Spouses Name \_\_\_\_\_ Employer \_\_\_\_\_ Telephone \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_ Telephone \_\_\_\_\_

Your E Mail address \_\_\_\_\_

## HEALTH INFORMATION

Have you had previous chiropractic care? Yes/No

Where? \_\_\_\_\_

When? \_\_\_\_\_

Why? \_\_\_\_\_

Were X-rays taken? \_\_\_\_\_

Reason for consulting the office:

I have a specific problem and require help only with this problem.

After my specific problem has been relieved, I am interested in strategies to insure the problem does not return

After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health

I have no symptoms and feel well. I am interested in strategies to help me to continue to feel well, or even better

What is your major complaint? \_\_\_\_\_

\_\_\_\_\_

Other complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting progressively worse  Yes  No  Constant  Comes and goes \_\_\_\_\_

Is this condition interfering with your  Work  Sleep  Daily routine  Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Others who treated this condition \_\_\_\_\_

\_\_\_\_\_

List surgical operations and the years \_\_\_\_\_

\_\_\_\_\_

Drugs you now take  Nerve pills  Pain Killers  Muscle relaxers  Pep Pills  Tranquilizers

Insulin  Birth control pills  Vitamins  Others  Aspirin

Have you been in an auto accident?  Past year  Past 5 years  over 5 years  Never

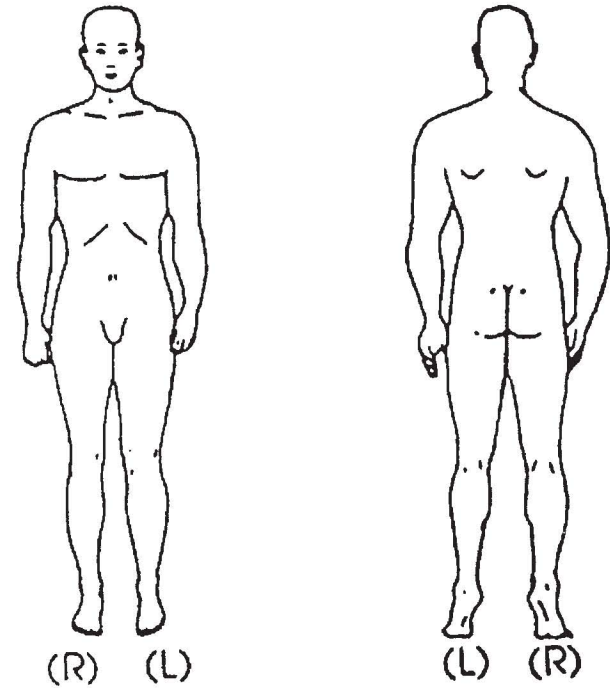
Describe: \_\_\_\_\_

Have you had any other personal injuries or accidents?  Past Year  Past 5 Years  Over 5 Years  None

Describe \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_

Please mark your areas of pain on the figures below.



Have you ever suffered from:

- \_\_\_\_\_ Allergies
- \_\_\_\_\_ Itching
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Fatigue
- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Eye Problems
- \_\_\_\_\_ Nose Problems
- \_\_\_\_\_ Ear Problems
- \_\_\_\_\_ Frequent Colds
- \_\_\_\_\_ Chronic Sinus Problems
- \_\_\_\_\_ Stomach or Digestion Problems
- \_\_\_\_\_ Elimination Problems
- \_\_\_\_\_ Heart Problems
- \_\_\_\_\_ Circulation Problems
- \_\_\_\_\_ High Blood Pressure
- \_\_\_\_\_ Low Blood Pressure
- \_\_\_\_\_ Difficulty Breathing
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ Cancer
- \_\_\_\_\_ Urinary Tract Infections
- \_\_\_\_\_ Menstrual Problems
- \_\_\_\_\_ Nervousness/Depression
- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Neck Pain or Stiffness
- \_\_\_\_\_ Low Back Pain
- \_\_\_\_\_ Foot Trouble
- \_\_\_\_\_ Swollen Joints
- \_\_\_\_\_ Tingling or numbness in
  - \_\_\_\_\_ Shoulders
  - \_\_\_\_\_ Arms
  - \_\_\_\_\_ Elbows
  - \_\_\_\_\_ Hands
- \_\_\_\_\_ Hips
- \_\_\_\_\_ Legs
- \_\_\_\_\_ Knees
- \_\_\_\_\_ Feet

HABITS:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

**INSURANCE INFORMATION:**

Is your condition due to an auto accident or job-related injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have Health Insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Name of Company \_\_\_\_\_ Policy # \_\_\_\_\_

Are you covered by Medicare? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Health Insurance # \_\_\_\_\_

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary 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 on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable. Payment is expected at time of visit.

Name of person responsible for payment \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_