CHIROPRACTIC CASE HISTORY
CONFIDENTIAL PATIENT INFORMATION

DATE_____

Name_____ Social Security ☐☐☐ ☐☐ ☐☐☐☐

Home phone # _____ Cell phone # _____

Address_____ City_____ State_____ Zip_____

Age_____ Birth Date_____ Marital: M S W D How Many Children?_____

Occupation _____ Employer _____

Address_____ Work Phone _____

Student at _____ Full Time _____ Part Time _____

Name of Husband or Wife _____ Occupation _____

Employer _____ Address _____

Name of Nearest Relative _____ Address_____ Phone _____

Is the condition due to injury or sickness arising out of employment?_____

Is the condition due to injury or sickness arising out of auto or other accident? _____

Number of days lost from work _____ Date symptoms appeared or accident happened_____

Have you ever had the same or a similar condition? Yes ___ No ___ If yes, when and describe:

_____

_____

Date of last physical examination _____

What operations have you had? _____ When? _____

Serious illness _____ When? _____

Have you ever suffered from:

1. Dizziness:_____
2. Backaches:_____
3. Heart Trouble:_____
4. Diabetes:_____
5. Hernia: _____
6. Arthritis:_____
7. Headaches:_____
8. Numbness:_____
9. Asthma: _____
10. Neuritis: _____
11. Digestive Disorders:_____
12. Nervousness:_____
13. Sinus Trouble: _____
14. Anemia: _____
15. Rheumatic Fever: _____
16. Cancer:_____

Purpose of this appointment _____

Other doctor seen for this condition _____

Have you been treated for any health condition by a physician in the last year? YES ☐ NO ☐

Describe_____

What medications or drugs are you taking? _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE: YES ☐ NO ☐ COMPANY_____

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

⇔Please turn page over for more information⇔