# Confidential Patient Case History

Date: _____ SSN# _____ /____ /_____

Name: _____ Age: _____Date of Birth: ___ /____ /_____

Address:_____ City: _____ Zip: ____

Home#: ( ____ ) _____ Cell#: ( ____ ) _____

Employer: _____ Position: _____

Work#: ( ____ )_____ Drivers License #: _____

Marital Status: Single: ___ Married: ____ Divorced: ____ Widowed: ____

Spouse's Name: _____

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## Health Information:

Condition due to a: Car Accident: Yes__ No __ (You were - Passenger: ___ Driver: ___ )

Height: ____ Weight: _____ Female: _____ Male: ____ Left handed: ____ Right handed: ___

Previous chiropractic care? Yes: ___ No: ___ Pregnant: Yes: ___ No: ____ N/A: _____

Please explain what your major complaint is:

_____

_____

_____

How long have you had this condition: _____ Is it getting worse: Yes: ____ No: ___

Is this condition interfering with your: Work: ____ Sleep: ____ Daily Routine: ____ Other: _____

Date of your last physical exam: ____ / ____ / _____ List surgical operations: _____

_____

Allergies: _____ Drugs you are taking: _____

_____

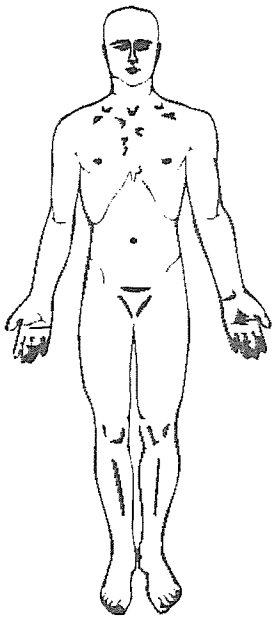
Have you had a personal injury, auto accident or on the job injury? Past year: ____ Past 5 years: _____

Describe: _____

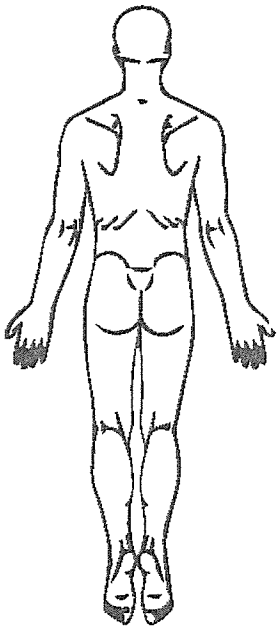
Have you missed time from work due to your condition: Yes: ____ No: _____

If yes please list dates missed from work: _____

**Please mark your areas of pain on the Figures below:**



Right /Left



Left / Right

**Check conditions you have or have had in the past.**

- ❒High blood pressure
- ❒Spinal disc injury
- ❒Backaches
- ❒Heart Trouble
- ❒Arthritis
- ❒Asthma
- ❒Depression
- ❒Digestive Disorders
- ❒Hepatitis
- ❒Cancer
- ❒Blood clots
- ❒Diabetes
- ❒Stroke
- ❒Sinus Trouble
- ❒Dizziness
- ❒Neck Pain
- ❒HIV Positive
- ❒Kidney disease
- ❒Migraine / Headaches
- ❒PACE MAKER
- ❒Prosthesis
- ❒Dialysis
- ❒Thrombosis

❒Medicare# _____ HMO: Yes ❒ No ❒

❒Medicaid# _____ HMO: Yes ❒ No ❒

❒Private Insurance _____ Insured: ❒Self ❒Other: _____

❒Workers Compensation Reported to Employer: Yes ❒ No ❒

If related to an Automobile accident do you have PIP? ❒Yes ❒No

Insurance Company name: _____

Reported to Auto Insurance Carrier? ❒Yes ❒No

PIP: Insured: _____ Policy #: _____

Claim # _____ Relationship to insured: _____

I understand and agree that health and accident policies are an arrangement between an insurance company 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 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 of any copays and 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:

Patient's Signature: _____

Responsible party (if minor): _____