# Confidential Case History

Please complete this questionnaire. Your answers will help us determine if we can correct your problem without drugs or surgery. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Name: _____ Date: ____/____/_____
How do you want to be addressed in this office: _____
Address: _____ Home Phone: (____)-____-_____ Birth Date: ____/____/_____
_____ Cell Phone: (____)-____-_____ Age: _____
_____ Marital Status: S M D W Children: _____
S.S.N.: ____-___-_____
Employer: _____ Occupation: _____
Address: _____ Work Phone: (____)-____-_____
_____ May we call you at work? _____
_____
Insurance Company: _____ Policy #: _____
Secondary/Supplemental Insurance Company: _____ Policy #: _____
Hobbies: _____
Spouse's Name: _____ Employer: _____
Spouse's DOB: ___/___/_____
Emergency Contact: _____ Phone: (____)-____-_____

Health Information: (Present reason for consulting this office)

[ ] I have no special problem; I understand the role of chiropractic in my general health care.
[ ] I have a symptom and I am interested in help with this specific problem; and I am interested in learning about my health potential and the role of chiropractic in improving my family's health.
[ ] I have a symptom and I am interested in help with this problem; and in learning how to prevent it in the future.
[ ] I have a symptom and I am only interested in help with this specific problem.

Chief Complaint: _____
Have you had prior chiropractic care? _____ Where? _____
When? _____ Why? _____
Were x-rays taken? _____ _____
Do you take any prescription medications? _____
Have you had any personal accident or injury (including auto accidents) and when? _____
_____
Have you had any surgical operations and when? _____
_____
Have you had any broken bones or dislocations and when? _____
_____
Have you ever been knocked unconscious and when? _____
_____
Is this condition interfering with your: Work _____ Sleep _____ Daily Routine _____

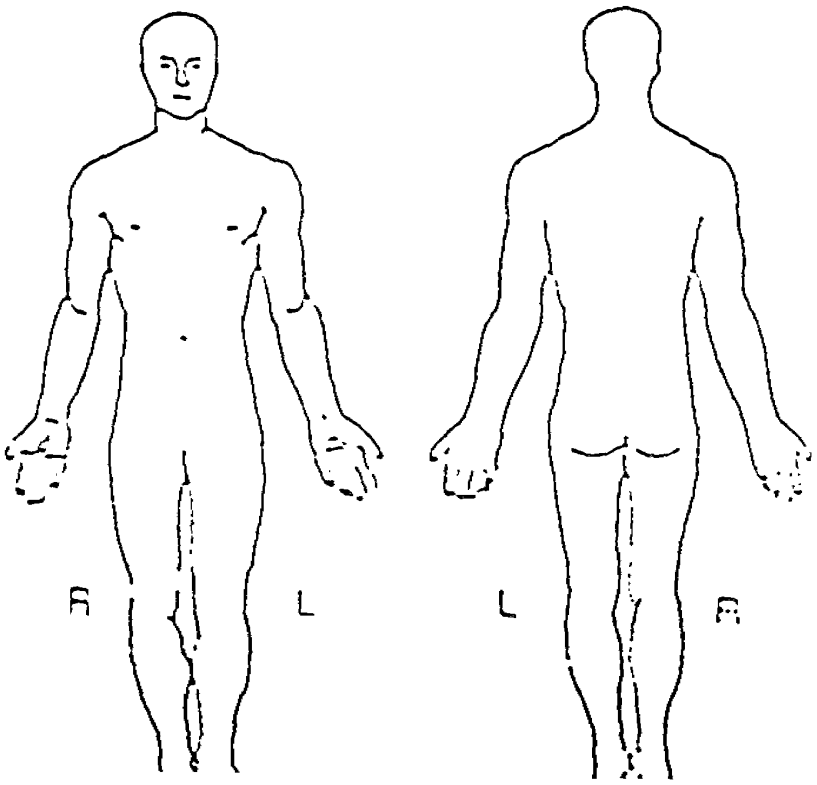
Referred to our office by: _____

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 _____ Hips
_____ Arms _____ Legs
_____ Elbows _____ Knees
_____ Hands _____ Feet

Please mark your areas of pain on the figures below:




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

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 to 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: _____