

PATIENT CASE HISTORY



REFERRED TO OUR OFFICE BY:

NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____ PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY #: _____

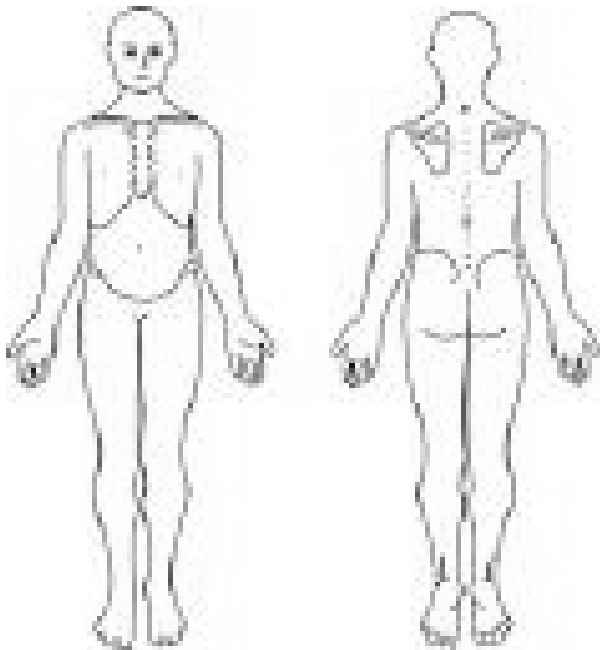
EMPLOYER _____ AGE _____

OCCUPATION _____ MARITAL STATUS _____

SPOUSE NAME _____ SPOUSE EMPLOYER _____

SPOUSE DATE OF BIRTH _____ S.S. #: _____

← CHIEF COMPLAINT/MAIN SYMPTOMS →



PLEASE LIST YOUR MAIN COMPLAINTS, IN ORDER OF SEVERITY.

1) _____

2) _____

3) _____

PLEASE MARK YOUR AREAS OF PAIN WITH AN "X" ON THE CHART.

MEDICAL HISTORY

MEDICATION _____

SURGERY/HOSPITALIZATIONS _____

BROKEN BONES/DISLOCATIONS _____

ANY OTHER INFORMATION YOU WOULD LIKE US TO KNOW _____

PRESENT COMPLAINTS

DATE OF ONSET _____ OCCURRED PREVIOUSLY? WHEN _____

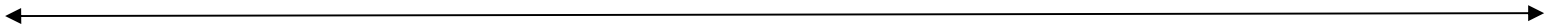
OTHER DOCTORS SEEN/THEIR RECOMMENDATIONS _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE _____ WHEN _____

PRIMARY CARE PHYSICIAN

WOULD YOU LIKE US TO SEND THEM

A REPORT? YES NO



I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S 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 THE DOCTORS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON 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.

I HEREBY AUTHORIZE TO DOCTOR TO EXAMINE AND TREAT ME CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED. **IT IS UNDERSTOOD AND AGREED THE AMOUNT PAID THE DOCTOR FOR XRAYS IS FOR EXAMINATION ONLY AND THE XRAY NEGATIVES WILL REMAIN THE PROPERTY OF THIS OFFICE, BEING ON FILE WHERE THEY MAY BE SEEN AT ANY TIME WHILE I AM AN ACTIVE PATIENT IN THIS OFFICE.** THE PATIENT ALSO AGREES THAT HE/SHE IS RESPONSIBLE FOR ALL BILLS INCURRED AT THIS OFFICE. THE DOCTOR WILL NOT BE HELD RESPONSIBLE FOR ANY PRE-EXISTING MEDICALLY DIAGNOSED CONDITIONS NOR FOR ANY MEDICAL DIAGNOSIS. PATIENT MAY OBTAIN COPIES OF THEIR FILE UPON REQUEST. COPYING FEES MAY APPLY.

PATIENT SIGNATURE _____ DATE _____

GUARDIAN SIGNATURE _____ DATE _____