PATIENT CASE HISTORY

REFERRED TO OUR OFFICE BY:

NAME ____ DATE _____________________________

ADDRESS ____

CITY _______________________________________ STATE __________________ ZIP ___________________

EMAIL ADDRESS ___________________________________ PHONE NUMBER _________________________

DATE OF BIRTH ____________________________________ AGE ___________________________________

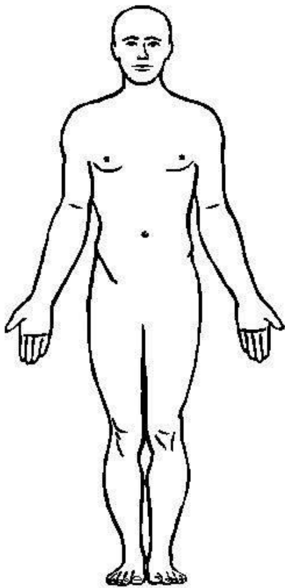
SSN __________________________________ MARITAL STATUS ___________________________________

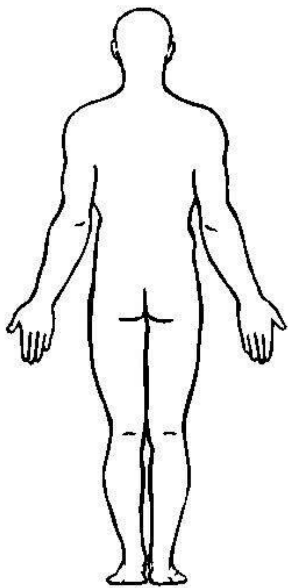
EMPLOYER ______________________________________ OCCUPATION ______________________________

SPOUSE NAME ____

WOULD YOU LIKE TO RECEIVE EMAILS ABOUT OFFICE EVENTS AND/OR TEXT MESSAGE APPOINTMENT REMINDERS? YES / NO CELLPHONE NUMBER _________________________ CARRIER______________________

MAIN COMPLAINTS / SYMPTOMS





LIST YOUR COMPLAINTS IN ORDER OF SEVERITY. PLEASE MARK YOUR AREAS OF PAIN WITH AN ‘X’ ON THE CHART.

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

PATIENT CASE HISTORY

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 A REPORT TO YOUR PRIMARY? 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 DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT UPON 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 TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT ME AND MY 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 _____________________