Welcome

ABOUT YOU

Today's Date:_____File #:_____

Name:_____

What you Prefer To Be Called:_____☐ Male☐ Female

Birth date:____/____/____Age:_____SS#:_____

Home Address:_____

_____
City State Zip

Home Phone#:_____

Cell Phone#:_____

Work Phone#:_____

Referred By:_____

Employer:_____How Long?_____

Employer's Address:_____

_____
City State Zip

Occupation:_____Work Phone #:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name:_____

Email:_____

INSURANCE INFO

Company Name:_____

Address:_____

Phone #:_____

Insured's SS# :_____

Group # (Plan, Local or Policy #):_____

Primary care Physician:_____

_____
City State Zip

Insured's Name:_____

Relation:_____Date of Birth____/____/____

Insured's Employer:_____

Please inform front desk of 2nd Insurance source.

IN EVENT OF EMERGENCY

Who should we contact?_____

Relation:_____

Home Phone #:_____

Work Phone #:_____

REASON FOR VISIT

Have you ever been treated by a chiropractor before? ☐Yes ☐No

If so, please explain:_____

The reason for this visit is a result of *(Please Circle):* work, sports, auto, trauma or chronic

*(Explain what happened):*_____

Please describe the pain & it's location:_____

When did condition begin?_____

Is this condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and goes

Is this condition interfering with you *(Please Circle):* work, sleep, or daily routine

If so, please explain:_____

Have you had this or similar conditions in the past? ☐Yes ☐No

If so, please explain:_____

Have you been treated by a Medical Physician for this condition? ☐Yes ☐No

If so, where?_____

- We invite you to discuss with us any questions regarding our services. The best health services are base on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no finacial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature_____Date_____

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME_____Date_____
(last) (first) (middle)

HEIGHT_____WEIGHT_____

CHILDREN (list ages & sex)_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

ACCIDENT RELATED | OTHER CAUSES

GENERAL
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Neck Pain
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, numbness or Cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet

GASTRO-INTESTINAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digesting
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear noise
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of the arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inadbility to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstration
- ☐ ☐ Vaginal discharge

Pregnant ☐Yes ☐No
Date of last period_____
Previous miscarriages ☐Yes ☐No

DATE OF LAST: (Approx.)
- _____Physical examination
- _____Blood test
- _____Chest x-ray
- _____Spinal x-ray
- _____Dental x-ray
- _____Urine test

	NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*Please list any prescription drugs now taken, allergies and past surgeries-_____

_____

_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

☐ Aids	☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ Foot Problems	☐ Measles	☐ Polio	☐ Typhoid Fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Ulcers
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Mumps	☐ Scarlet Fever	☐ Venereal Disease
☐ Arteriosclerosis	☐ Emphysema	☐ Heart Disease	☐ Pacemaker	☐ Stroke	

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign your name_____Date_____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

CASE HISTORY

PAIN CHART

About you

Name:_____File #_____

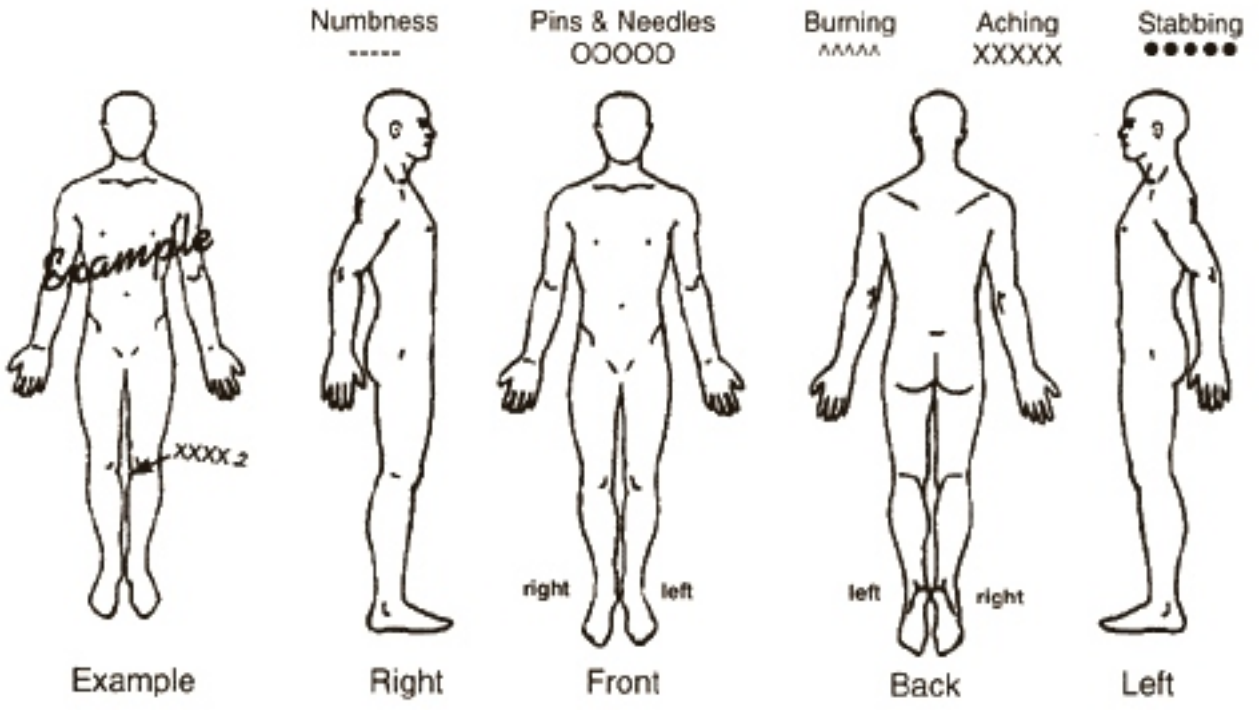
Please describe your condition:_____

_____

Signature:_____Date:___/___/___

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown below in the example.



Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

1 2 3 4 5 6 7 8 9 10

DOCTOR'S NOTES

_____

_____

_____

_____