



# Chiropractic Case History

## CONFIDENTIAL PATIENT INFORMATION

Name \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status  M  S  W  D

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Name of nearest relative \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Is your condition due to an accident?  Y  N

*If yes:* Type of accident  Auto  Work  Home

To whom have you made a report of your accident?

Auto Insurance  Employer  Workers' Comp  Other \_\_\_\_\_

Attorney's name, if applicable \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

Is your condition getting progressively worse?  Y  N  Not Sure

Rate the severity of your pain from **1** (Least pain) to **10** (Severe pain) \_\_\_\_\_

Location of pain \_\_\_\_\_

Type of pain  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_ Is it constant, or does it come and go? \_\_\_\_\_

Does it interfere with  Work  Sleep  Daily Routine  Recreation

Activities that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself-not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collection from my insurance company. If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Health Insurance:  Yes  No Company \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_