

## CONFIDENTIAL PATIENT CASE HISTORY

Today's Date \_\_\_\_\_ Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell/Alt.Phone \_\_\_\_\_  
Social Security# \_\_\_\_\_ Occupation/Company \_\_\_\_\_  
E-Mail Add. \_\_\_\_\_  
Company Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Spouse Info:** Name \_\_\_\_\_ Number of children/ dependents \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_

**Insurance Info:**

Primary Carrier: \_\_\_\_\_ Secondary \_\_\_\_\_  
Who referred you to this office? \_\_\_\_\_  
Is this an accident? \_\_\_\_\_ Yes \_\_\_\_\_ No If so, date of injury \_\_\_\_\_  
( ) Auto accident ( ) State Compensation ( ) On the Job Injury ( ) other  
Have you reported a work related injury to your employer? \_\_\_\_\_ yes \_\_\_\_\_ no  
How did you get injured? \_\_\_\_\_  
Name and Address of Attorney advising you \_\_\_\_\_

**List your main complaints in order of severity:**

1. \_\_\_\_\_ For how long? \_\_\_\_\_ # previous incidents \_\_\_\_\_  
2. \_\_\_\_\_ For how long? \_\_\_\_\_ # previous incidents \_\_\_\_\_  
3. \_\_\_\_\_ For how long? \_\_\_\_\_ # previous incidents \_\_\_\_\_

Have you ever had Chiropractic care before? \_\_\_\_\_ If so when? \_\_\_\_\_  
By whom? \_\_\_\_\_ For what condition? \_\_\_\_\_

**List other Doctors consulted on above complaints:**

1. \_\_\_\_\_ Address \_\_\_\_\_  
2. \_\_\_\_\_ Address \_\_\_\_\_

Have you had this or a similar condition in the past? \_\_\_\_\_ yes \_\_\_\_\_ no  
Is this condition interfering with your \_\_\_\_\_ work \_\_\_\_\_ sleep \_\_\_\_\_ daily routine  
What do you believe is wrong with you? \_\_\_\_\_  
List all medications you are currently taking and for what condition? \_\_\_\_\_

**Past History:** (Date, Severity and type of injury)

Motor vehicle accident: \_\_\_\_\_  
Serious Falls: \_\_\_\_\_  
Fractures: \_\_\_\_\_  
Surgery: \_\_\_\_\_  
Tumors: \_\_\_\_\_  
Recent x-rays: \_\_\_\_\_  
Cosmetic Surgeries: \_\_\_\_\_  
Date of last menstrual period: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Other: \_\_\_\_\_

**Tobacco use:** Y/N \_\_\_\_\_ per day **Alcohol use:** Y/N \_\_\_\_\_ per day **Drugs:** Y/N \_\_\_\_\_ per day  
Are you aware of any inherited diseases in your family? \_\_\_\_\_

**Notice:** Not all patients require x-rays to determine or verify a diagnosis, type of treatment or length of treatment. If your exam warrants x-ray analysis the following policy prevails:

- A. The fee paid for x-rays is for analysis only. The film itself is the property of this office.
- B. The Doctor will inform you after your consultation and exam if yours is a condition that may benefit from treatment and will accept you as a patient.

Payment for each visit is expected in full at the time of service until your deductible is satisfied. After the deductible is met, payment for expenses not covered by insurance are required. Co-pays are due on each visit.

I request that payment of authorized Medicare benefits, other insurance benefits, or my Attorney, if applicable, be made either to me or Dr. James for any services furnished by that physician. I authorize any holder of medical information about me to be released to the Healthcare Financing Administration, my insurance company or any company liable for payment, any information needed to determine these benefits or the benefits payable for related services.

**Notice:**

**I understand and agree that all services are directly to me and that I am personally responsible for payment upon delivery of service unless prior arrangements are made. If my account is turned over to collections, all collection fees will be in addition to the account balance.**

Signature: \_\_\_\_\_

**Doctor notes:**