

To expedite your visit, please print and complete this form and bring it with you on your initial visit.

CONFIDENTIAL PATIENT CASE HISTORY

TODAY'S DATE _____ NAME _____
NICKNAME _____
ADDRESS _____
CITY _____ STATE _____
ZIP _____
HOME PHONE _____ ALT. PHONE _____
SOCIAL SECURITY # _____ / _____ / _____ BIRTHDATE _____
OCCUPATION/
COMPANY _____
COMPANY _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

SPOUSE: NAME _____ SOCIAL SECURITY# _____
_____ / _____ / _____
BIRTH DATE _____ EMPLOYER _____
ADDRESS _____ CITY _____
STATE _____
ZIP _____ PHONE _____

INSURANCE INFORMATION

PRIMARY CARRIER _____ SECONDARY _____
WHO REFERRED YOU TO OUR 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: ___ Y ___ N
HOW DID YOU GET INJURED? _____
NAME AND ADDRESS OF ATTORNEY ADVISING YOU _____

LIST YOUR MAIN COMPLAINTS IN ORDER OF SEVERITY:

1. _____ FOR HOW LONG? _____

2. _____ FOR HOW LONG? _____

3. _____ FOR HOW LONG?

_____ 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 _____

OTHER: _____

ALLERGIES: _____

ARE YOU AWARE OF ANY INHERITED DISEASES IN YOUR FAMILY? _____