Confidential Case History

Please complete this questionaire. Your answers will help us determine if we can correct your problem without drugs or surgery. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Name: _____Date: __/___/___
How do you want to be addressed in this office:_____

Address:_____
Home phone:_____Age:___Birthdate:__/__/__ cell #_____
Social Security #____/_____/_____
Employer:_____Address:_____
Employer phone:_____May we call you at work?____
Occupation:_____ Hobbies:_____
Spouse's name:_____Employer:_____
Emergency contact:_____

HEALTH INFORMATION:
Have you had prior chiropractic care ? _____
Where?_____
When?_____Why?_____
_____
Were x-rays taken?_____

Do you take any prescription medications?_____
Have you had any personal accident or injury and when?_____
_____

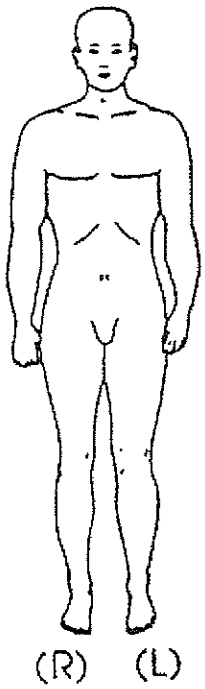
List surgical operations and years:_____
_____

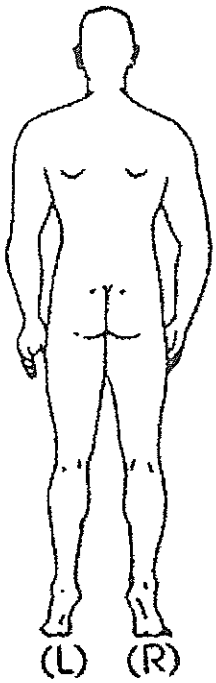
Is this condition interfering with your work__sleep____daily routine___

How were you referred in to our practice?_____
_____

Date of Last Physical Examination _____

Please mark your areas of pain on the figures below.





HABITS:	Heavy	Moderate	Light	None
Alcohol	____	____	____	____
Coffee	____	____	____	____
Tobacco	____	____	____	____
Drugs	____	____	____	____
Exercise	____	____	____	____
Sleep	____	____	____	____
Appetite	____	____	____	____

Have you ever suffered from:

_____ Allergies
_____ Itching
_____ Dizziness
_____ Fatigue
_____ Headaches
_____ Eye Problems
_____ Nose Problems
_____ Ear Problems
_____ Frequent Colds
_____ Chronic Sinus Problems
_____ Stomach or Digestion Problems
_____ Elimination Problems
_____ Heart Problems
_____ Circulation Problems
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Difficulty Breathing
_____ Stroke
_____ Cancer
_____ Urinary Tract Infections
_____ Menstrual Problems
_____ Nervousness/Depression
_____ Arthritis
_____ Neck Pain or Stiffness
_____ Low Back Pain
_____ Foot Trouble
_____ Swollen Joints

Tingling or numbness in

_____ Shoulders _____ Hips
_____ Arms _____ Legs
_____ Elbows _____ Knees
_____ Hands _____ Feet

INSURANCE INFORMATION:

Is your condition due to an auto accident or job-related injury? _____ Yes _____ No

Do you have Health Insurance? _____ Yes _____ No

If yes, Name of Company _____ Policy # _____

Are you covered by Medicare? _____ Yes _____ No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable. Payment is expected at time of visit.

Name of person responsible for payment _____

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____