CONFIDENTIAL CASE HISTORY

Date_____

Name_____ Home Phone_____ Cell Phone_____

Address_____ Zip Code_____ E-mail_____

Age_____ Birth Date_____ Marital: M S W D How Many Children_____

Occupation_____ Employer_____

Address_____ Office Phone_____

Name of Wife or Husband_____ Occupation_____

Employer_____ Office Phone_____

Referred By_____

Are you insured: ☐ Yes ☐ No

My Company_____ Address_____

Company of Person Responsible For Injuries_____

Date of Accident: _____Hour _____AM _____PM Location:_____

How Did Accident Occur_____

_____

If Auto Collision, Were You Struck From: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Have You Had Similar Accidents or Injuries Before?_____

What Operations Have You Had?_____ When?_____

Unusual Diseases?_____ When?_____

Serious Diseases?_____ When?_____

Do You Have An Attorney That Has Advised You in This Case? ☐ Yes ☐ No

Name_____ Address_____ Telephone_____

Have You Lost Any Days of Work?_____ Dates:_____

Have You Been Treated For Any Health Condition By A Physician in the Last Year? ☐ Yes ☐ No

Describe_____

CHECK SYMPTOMS:

☐ Headache	☐ Pins & Needles In Legs	☐ Fainting
☐ Neck Pain	☐ Numbness in Fingers	☐ Loss of Smell
☐ Neck Stiff	☐ Numbness in Toes	☐ Loss of Taste
☐ Sleeping Problems	☐ Shortness of Breath	☐ Diarrhea
☐ Back Pain	☐ Fatigue	☐ Feet Cold
☐ Nervousness	☐ Depression	☐ Hands Cold
☐ Tension	☐ Lights Bother Eyes	☐ Stomach Upset
☐ Irritability	☐ Loss of Memory	☐ Constipation
☐ Chest Pain	☐ Ears Ring	☐ Cold Sweats
☐ Dizziness	☐ Face Flushed	☐ Fever
☐ Head Seems Too Heavy	☐ Buzzing in Ears	☐
☐ Pins & Needles in Arms	☐ Loss of Balance	☐

Symptoms Other Than Above_____

What Medication or Drugs Are You Taking?_____

I understand and agree that health and accident insurance 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.

Patient's Signature:_____ SS #_____ Date:_____

Guardian or Spouse's
Signature Authorizing Care:_____ Date:_____

Information Taken By:_____ Date:_____