Confidential Patient Case History

Welcome. In order to provide you with optimal care, please complete this questionnaire. Your answers will help me determine the best approach to help you in successfully attaining your health goals.
THANK YOU.

Name (Last, First)________________________Driver's License #__________________Social Security #_____________

Birth date ___________ Age ____

Address _____________________________ City _____________________________ State ________ Zip __________

Phone # (Daytime) ____________(Evening)____________(Cell) ____________ Email ____________________________

(Please circle best contact number)

Employer __________________________________ Occupation ___________________ Phone ___________________

Address _____________________________ City _____________________________ State ________ Zip __________

Spouse's Name________________________ # of Children ________ Their Ages ______ _______ _____ _____ ______

Spouse's Employer __________________________ Occupation ___________________ Phone ___________________

Address _____________________________ City _____________________________ State ________ Zip __________

Next of kin or other to reach in case of emergency _______________________________ (Relation) _______________

Phone _________________ Address _____________________________ City ______________ State ___ Zip _______

How did you hear about our office? __________________________

Previous Chiropractic care? Yes □ No □ Date __________ Doctor's Name ___________________________

Were X-rays taken? Yes □ No □ Date _____________________

Insurance: Yes □ No □ If Yes, provide copy of card

Company name _______________________ Type: □ Medicare □ HMO □ PPO □ W.C. □ Auto Other____________

Please, list most important health concerns / reasons / goals for consulting this office.

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If more room needed for previous answers, please attach separate piece of paper.
(Please turn over to complete the other side of this form)

Have you ever had any … Falls? Yes ☐ No ☐ Auto accidents? Yes ☐ No ☐ Injuries? Yes ☐ No ☐ Please describe →	Age at time or month & year	Type of accident (briefly describe)	Treatment and/or Complications
Have you ever … Had Surgery? Yes ☐ No ☐ Been hospitalized? Yes ☐ No ☐ Please explain →	Age at time or month & year	Type of surgery or reason for hospitalization	Complications if any and/or Comments
Have you ever … any bones? Dislocated Yes ☐ No ☐ Fractured Yes ☐ No ☐ Broken Yes ☐ No ☐ Please describe →	Age at time or month & year	Area(s) involved, which bone(s) associated with what injury	Treatment and/or Complications
Have you ever suffered from a major or lengthy illness? (childhood and adult) Yes ☐ No ☐ Please explain →	Age at time or month & year	Illness	Complications if any and/or Comments
Date of last physical exam?	Reason for exam and results ________________		
Date of most recent x-rays. Include CT scan & MRI	Area(s) x-rayed and reasons ________________		
Are you presently taking medications or drugs? Yes ☐ No ☐ List or provide copy of list	Name of drug(s)	Doses/Day	Length of time taking and for what condition
Do you take vitamins or minerals? Yes ☐ No ☐ List or provide copy of list	Type/Brand	Amount / Frequency	

Do you wear … Heel lifts? Yes ☐ No ☐ Arch supports? Yes ☐ No ☐ Sole lifts? Yes ☐ No ☐ Inner soles? Yes ☐ No ☐	Have you ever had a spinal tap or spinal injection? Yes ☐ No ☐ Please explain	Were you ever knocked unconscious? Yes ☐ No ☐ Please explain	If female: Are you, or may you be pregnant now? Yes ☐ No ☐	Do you suffer from any conditions other than those for which you are now consulting this office? Yes ☐ No ☐ Please explain

Habits:	Heavy	Moderate	Light	None	Habits:	Heavy	Moderate	Light	None
Alcohol	______	______	______	______	*Exercise*	______	______	______	______
Coffee	______	______	______	______	*Sleep*	______	______	______	______
Tobacco	______	______	______	______	*Appetite*	______	______	______	______
Drugs									

As a courtesy to our patients, we will bill your insurance company for you at no charge. Any amount paid to our office by the insurance company will be credited to your account. However, you must clearly understand and agree that for all services rendered to you in our office, you are charged directly and are personally responsible.

Signature ______________________________ Date ______________________