CASE HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original case history up to date, please provide us with the following information.

Name: _____Date: _____
Has your address or phone number changed since you were in last? ☐ Yes ☐ No
If so, please fill out the following:
Address: _____City:_____State:_____ Zip:_____
Telephone (H): _____ (W): _____ (C):_____
E-Mail Address: _____

Is your visit to this clinic in reference to an accident: ☐ Yes ☐ No
If yes, was it: ☐ Work Comp ☐ Automobile ☐ Personal Injury ☐ Other: _____
List present complaints (describe fully): _____
_____
Duration of present condition: _____. What do you believe caused this condition:
_____
_____
On a scale of 1 to 10 (1 = no pain, 10 = severe) where would you rate your pain:_____
Describe any falls, surgery, and/or accidents since your last visit: _____
_____
_____
Since your last visit here, have you consulted another Doctor? ☐ Yes ☐ No
If so, please give the Doctor's name: _____
and condition for which you were treated: _____
Are you presently taking any medications-prescription or over-the counter? ☐ Yes ☐ No
If so, what drugs? _____
Has your insurance changed since you were in last? ☐ Yes ☐ No
If so, name of the company: _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: _____