CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION DATE_____

Name_____SSN_____Age_____Birth Date_____

Address_____City_____State_____Zip_____

Home Phone_____ Mobile Phone_____ Work Phone

_____

Email Address_____Marital Status: M S W D How Many Children?_____

Occupation_____Employer_____

Address_____City_____ State_____ Zip_____

Student at_____Full Time/Part Time

Name of Husband or Wife _____Occupation _____

Employer _____Address _____City_____ Zip_____

Name of Nearest Relative _____

Address_____Phone_____

How did you find out about our office? _____

Purpose of this appointment_____

Is the condition due to injury or sickness arising out of *employment*? YES NO

If yes, state condition:_____

Is the condition due to injury or sickness arising out of *auto or other accident*? YES NO

If yes, state condition:_____

Number of days lost from work _____Date symptoms appeared or accident happened_____

Have you ever had the same or a similar condition? YES NO

If yes, when and describe_____

_____

Date of last physical examination_____

What operations have you had?_____

When?_____

Serious illness_____

When?_____

Family Medical Doctor

When all of your doctors work together it benefits you.

May we have permission to update your medical doctor regarding your care at this office? YES NO

Name_____Address_____City_____Zip_____

Other doctors seen for this condition_____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe_____

What medications or drugs are you currently taking and why?_____

_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE: YES NO COMPANY_____

Patient's Signature _____Date_____

Guardian's Signature Authorizing Care_____Date_____

ALLIANCE CHIROPRACTIC HEALTH CENTER

Patient Name:_____ **Date**:_____

1. What is your major symptom?_____
2. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes No Same Better Gradually Worse
   If yes, when and how?_____
3. How frequent is the condition? Constant Daily Intermittent Night Only
   How long does it last? All Day_____ Few Hours_____ Minutes_____
4. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes No If yes, describe_____
   Are there other unrelated health problems? Yes No
   If yes, describe_____
5. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing
   Other_____
6. Is there anything you can do to relieve the problem? Yes No
   If yes, describe_____
   If no, what have you tried to do that has not helped?_____
   _____
7. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting
   Other_____
8. Have you had any broken bones? Yes No
   If yes, please list and give dates_____
   _____
9. List any major accidents you have had other than those that might be mentioned above:
   _____
10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes No
    If yes, please explain_____
    _____
11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain
12. Remarks:_____
    _____
    _____

NO PAIN (0) _____ **EXTREME PAIN (10)**

(5)

Please place an "X" on the line above to indicate your level of problem.

Doctor's Signature _____ Date _____