Rebalance ▸ Restore ▸ Revitalize

Case History

NAME ____
(Last) (First) (M.I.)

ADDRESS ______________________________ PHONE ______________

CITY______________________ STATE ______ ZIP__________ E-MAIL ______________

DATE OF BIRTH ______________ MARRIED ________ SINGLE ________ NUMBER OF CHILDREN ________

EMPLOYED BY ______________________ BUSINESS PHONE ______________

SPOUSE ______________________ EMPLOYED BY______________________

REFERRED BY______________________SOCIAL SECURITY #______________________

CHIROPRACTIC CARE IN YOUR PAST?______________ WHERE? ______________ WHEN? ______________

ACUPUNCTURE IN YOUR PAST? ______________ WHERE? ______________ WHEN? ______________

HEALTH INSURANCE? _______ INSURANCE COMPANY______________________

SUBSCRIBER ON CARD ______________________________

POLICY & GROUP # ______________________________

BIRTHDATE OF INSURED ______________

DATE OF ACCIDENT/INJURY/ONSET OF ILLNESS _________ / _________ / _________

RELATIONSHIP TO PATIENT: 1. SELF _________ 2. SPOUSE _________ 3. CHILD _________ 4. OTHER _________

____ INSURANCE PATIENT: Insurance is a contract between the insured (patient) and the insurance company. This office does not accept assignment for the insurance benefits. We will, however, supply the insured with all necessary information needed to submit claims easily and quickly. If payment is not made the day services are rendered, a $2.00 billing charge will be applied to your account. Additionally, we will be happy to submit the claim for a $2.00 service charge, but the responsibility for payment of services rendered remains with the patient.

____ PERSONAL INJURY: If you have coverage, upon verification, it will be accepted. In such a case, this office will accept assignment for the insurance benefits with the understanding that the patient remains fully obligated for the liabilities of services rendered if applicable insurance will not cover such charges. Your insurance will be billed directly.

____ WORKMAN'S COMPENSATION: We ask you to bring written verification from your employer for treatment. Without such verification of injury, you will be responsible for fees.

____ MEDICARE: This office does not file Medicare paperwork. Services rendered at this office are not billable or reimbursaable by medicare.

Major Complaint ____

____

____

Stress/Emotional Complaint ____

____

____

Have you had this condition in the past? ______________________________

Date you first noticed symptoms? ______________________________

Other Doctors you have seen for this condition? ______________________________

Major Illness ______________________________

Accidents, Falls, Etc. ______________________________

Hospitalizations ______________________________

Surgeries ______________________________

(turn page over)

Current Medications ______________________________

Current Nutritional Supplements ______________________________

Amount of water per day? ____________ Soda? ____________ Coffee? ____________

Smoke Cigarettes? _______ How much? _______ Last Physical Exam ____________

Do you Exercise Regularly? _______ How often? _______ What? ____________

PLEASE CHECK THE SPACE FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD PREVIOUSLY. THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL

______ Allergy (list) ________
____
______ Asthma
______ Convulsions/Seizures
______ Dizziness
______ Fainting
______ Headache
Migraine Tension
______ Numbness

MUSCLE & JOINT

______ Arthritis
______ Low Back Pain (1-10) _____
______ Neck Pain (1-10) _____
______ Pain between shoulders
______ Scoliosis

PAIN OR NUMBNESS IN:

______ Shoulder ______ Arms
______ Elbows ______ Hands
______ Hips ______ Legs
______ Knees ______ Feet
Please rate (1-10)

GASTRO-INTESTINAL

______ Constipation
______ Diarrhea
______ Difficult digestion
______ Gall Bladder problems

EYES/EARS/NOSE & THROAT

______ Frequent colds
______ Earache
______ Ear noises/ringing
______ Nasal obstruction
______ Nosebleeds

CARDIO-VASCULAR

______ Abnormal heart beat
______ High blood pressure
______ Low blood pressure
______ Poor circulation
______ Swelling of extremities

RESPIRATORY

______ Chest pain
______ Chronic cough
______ Difficult breathing

URINARY

______ Bed-Wetting
______ Frequent urination
______ Kidney infection
______ Kidney stones
______ Prostate trouble

FOR WOMEN ONLY

______ Cramps/Backache
______ Irregular cycle
______ Perimenopause
______ Sinus infection
______ Menopause

SKIN

______ Bruise easily
______ Dryness
______ Rash
______ Varicose vein

IMMUNIZATIONS

______ Flu ______ Polio
______ DPT ______ MMR
Any adverse reaction to vaccine?
____

WOMEN ONLY

I ______________________ HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT.

SIGNATURE ______________________ DATE ______________

I hereby give permission to the doctor to administer treatment and perform such general procedures as she/he may deem necessary in the diagnosis and/or treatment of my condition.

I understand fees are payable when services are reaceived, should any legal action be necessary in order to collect fee, all costs associated with the collection and attorney fees shall be payable by the patient.

SIGNATURE ______________________ DATE ______________

(please check if applicable)

____ AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process my claim(s) for reimbursement of charges incurred by me as a result of professional services by you and I hereby release you of any consequences thereof.

____ AUTHORIZATION TO PAY DIRECTLY TO DOCTOR: In consideration of the chiropractic services rendered and to be rendered by her, I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe her by my attorney, out of the proceeds of any settlement of my case and/or by any insurance company obligated to reimburse me for the charges for services rendered.

APPROVAL SIGNATURE ______________________