

**Required For Your Case History File**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
SSN \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Marital Status M S W D Spouses Name \_\_\_\_\_ Number of Children \_\_\_\_\_  
Names and Ages of Children \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext \_\_\_\_\_ May we contact you at work? Yes No  
Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Relation \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_  
If you were not referred, what helped you choose our office? \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Is this condition due to an injury or sickness that is work related or an auto accident? (circle one) Yes No  
If Yes: Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_  
Please describe in detail \_\_\_\_\_

If NO: If this was not due to a **recent** accident when did symptoms appear? \_\_\_\_\_  
Were you doing anything at the time? Yes No  
If yes, what? \_\_\_\_\_

Have you ever had same or similar condition? Yes No If yes, when and describe \_\_\_\_\_

Have you lost days from work? \_\_\_\_\_  
Date of last physical examination \_\_\_\_\_ Female: Are you pregnant? Yes No

List any surgeries \_\_\_\_\_  
List serious illnesses \_\_\_\_\_

Is the condition getting progressively worse? Yes No Constant Comes and Goes  
Is the condition interfering with your: Work Sleep Daily Routine Other \_\_\_\_\_

How long has it been since you felt good? \_\_\_\_\_  
What do you believe is wrong with ;you? \_\_\_\_\_

Have you seen other doctors for this condition? If so what specialty \_\_\_\_\_  
Have you been under a doctor's care in the last year? Yes No

Describe \_\_\_\_\_  
Are you taking any supplements? \_\_\_\_\_ What kind? \_\_\_\_\_

Are you taking any medications or drugs? \_\_\_\_\_ What kind? \_\_\_\_\_

Do you wear orthotics/ insoles in your shoes? \_\_\_\_\_  
Have you ever been under Chiropractic Care? Yes No Doctor's Name \_\_\_\_\_  
When was your last treatment? \_\_\_\_\_ Results? \_\_\_\_\_

**PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT!**

Name of person responsible for payment \_\_\_\_\_

*I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and I. Further more, I understand that this chiropractic office will prepare any necessary report and forms to assist me in making collections form the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks make out to me, to be credited to my account. 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.*

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_