TOBIN FAMILY CHIROPRACTIC CENTER
CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

Name___________________________________

Address__________________________________

____

Home phone (_______) __________________

Work phone (_______) __________________

Cell phone (________) ___________________

Best day/ time to reach me: ________________

…at this number: Cell Home Work

Date of Birth: ____________________________

Social Security #________-______-__________

Email Address_____________________________

Occupation_______________________________

Marital Status: M S W D

Spouse's Name___________________________

In case of emergency name & phone #:

____

Your Employer Name/ Address (for insurance):

____

____

____

Who may we thank for referring you to our office? ____

HEALTH INFORMATION: Have you had previous chiropractic care? ____________________

What is your main complaint?____

____

How long have you had this condition?____

Have you had similar conditions in the past?____

What aggravates your condition?____

Is this getting progressively worse? Yes No Is this condition: Constant Comes and Goes

Is this condition interfering with your: Work Sleep Daily Routine Other____________________

What are your additional complaints? ____

____

How long has it been since you really felt good?____

Other doctors who have treated this condition____

Are you wearing: Heel Lifts Foot Orthotics Arch supports

Please list ANY medications (prescription or over-the-counter) that you now take: ________________

____

Vitamins/ Herbs/ Homeopathic Remedies: ____

RELATED HEALTH HISTORY

Have you ever been in an auto accident? YES NO Date(s):_______________________________

Please describe: ____

What types of treatments and/or chiropractic care did you receive to correct any injuries sustained?

____

Have you ever had any other type of accident (slip & fall, sports injury, childhood injury, etc) _______

____

PAST MEDICAL HISTORY

Date of last Physical Exam_____________ Physician's Name_________________________________

Please list ALL surgeries, major or chronic illnesses, childhood diseases, pregnancies, etc. _________

____

____

____

SOCIAL HISTORY (EXERCISE HABITS, ALCOHOL CONSUMPTION, SMOKING HISTORY) –

____

____

* Some health conditions run in families, whether they are the result of genetics or common lifestyle. Information about family members can give us a better understanding of your total health picture.

RELATIONSHIP HEALTH PROBLEMS

____

____

____

INSURANCE INFORMATION

In order to properly bill insurance claims, we need *all* of the following information:

POLICY HOLDER / INSURED'S NAME:____

RELATIONSHIP TO PATIENT: _________________SOCIAL SECURITY #: _______________________

DATE OF BIRTH: ___________________ EMPLOYER PHONE NUMBER: _______________________

EMPLOYER NAME AND ADDRESS: ____

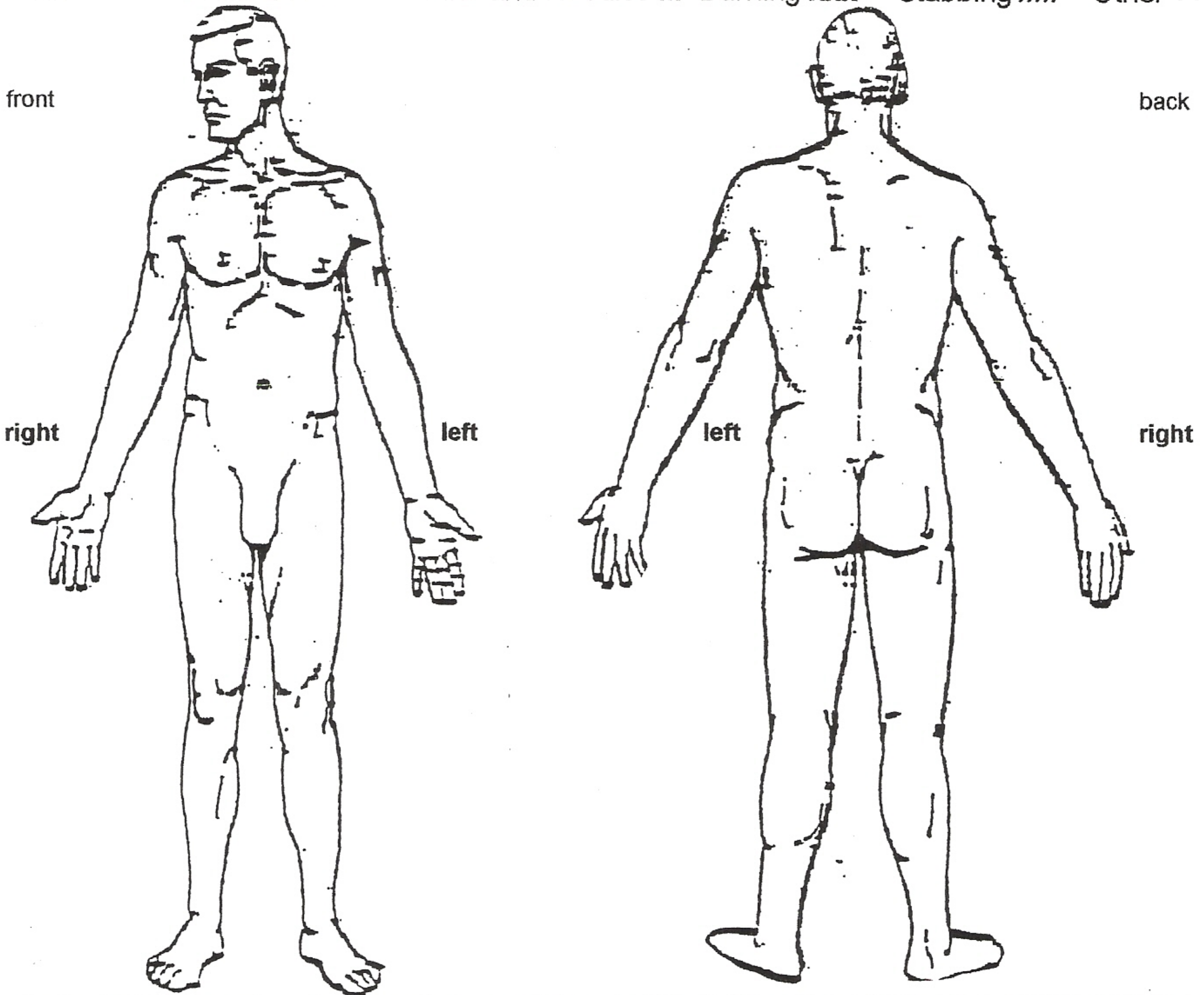
____

Please present your insurance card(s) to the receptionist so that we may verify your chiropractic benefits. We look forward to taking excellent care of your spinal health. THANK YOU!

Name:________________________________ Date:________________

Mark the areas on your body where you feel the following sensations:

Pain ^^^ Numbness **ooo** Pins and Needles **...** Burning **xxx** Stabbing ///// Other **+++**



Indicate the severity of your pain by marking an "X" at the appropriate point on the pain line:

How bad is your neck pain now?
No Pain (0)________________________________ Worst possible (10)

How bad is your back pain now?
No Pain (0)________________________________ Worst possible (10)

How bad is your arm pain now?
No Pain (0)________________________________ Worst possible (10)

How bad is your leg pain now?
No pain (0)________________________________ Worst possible (10)

Tobin Family Chiropractic Center

Service	Fee
New Patient Examination	$95
Established Patient Re-examination	$50
Radiographic X-Rays taken	full spine $150
Radiographic X-Rays taken	per area $50
X-Ray Analysis and Explanation	No Charge
Chiropractic Adjustment	$60
Cervical Traction Unit for Home Use	$50
Vitamins, Pillows, Supports and other supplies	Prices Vary

Individual and Family Chiropractic Care Plans are available and will be discussed during the first 3 visits of care.

Financial Policy:

I acknowledge the above fee schedule, and realize that I am ultimately responsible for my bill. I understand that I may need more care than my insurance company will authorize or cover and I agree to pay for that care.

If I do not have insurance to cover the services rendered, I understand that payment is due in full on the day that services are rendered, unless other arrangements are made.

If I have insurance that requires me to pay a co-payment, I understand that payment of my co-pay is due in full on the day that services are rendered, unless other arrangements are made. I understand that all non-covered supplies must be paid for on the day they are received, and that in order to continue receive treatments, the PATIENT PORTION of my balance may not exceed $100.

Signature: ______________________________ **Date:** ____________________

For your convenience, we accept Cash, Checks, Visa, and MasterCard. As a courtesy to you, our patient, we will submit claims to your insurance company. If claims are not paid within 30 days, we will forward you a copy of your bill. Since the insurance contract is between YOU and YOUR INSURANCE COMPANY, we suggest that you contact them for the status of payment, as you are ultimately responsible for your bill. Any additional information needed from our office will be supplied with pleasure.