CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Social Security # _____ Driver Lic. # _____
Age _____ Birthdate _____ Sex _____ Status M S W D No. Children _____
Occupation _____ Employer _____ Years Employed _____
Employer's Address _____ City _____ State _____ Phone _____
Spouse's Name _____ Occupation _____ Employer _____
Person responsible for this account _____ Referred by _____
What is your major complaint? _____
_____
Other complaints _____
How long have you had this condition? _____ Have you had this or similar conditions in the past? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐
Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other _____
How long has it been since you really felt good? _____
List surgical operations: _____
_____
Are you taking any medications? _____ What kind? _____
Any non-prescription drugs? _____ What kind? _____
OTHER DOCTORS SEEN FOR THIS CONDITION: MD ☐ DC ☐ DO ☐ DDS ☐
Doctor's Name _____ Diagnosis _____
X-rays _____ Urinalysis _____ Blood Tests _____ Other _____
Treatment: Medication _____ Physiotherapy _____
Results _____ Length of time under care _____
Were you off work? _____ If so, how long _____ Have you returned to your same job? _____ If not, why _____

INSURANCE INFORMATION:
Are you covered by Medicare? Yes ☐ No ☐ Medicare # _____ State Insurance Aid? Yes ☐ No ☐
Do you have any group, union or personal health and accident insurance? Yes ☐ No ☐
Name of Insurance Company _____ Claim # _____ Group # _____
Address _____ Phone _____ Agent _____
Additional Insurance Company _____ Claim # _____ Group # _____
Address _____ Phone _____ Agent _____
Is your condition due to an accident? ☐ illness ☐ Other _____

ACCIDENT INFORMATION:
Did your accident occur while at work? Yes ☐ No ☐ Were you involved in an automobile accident? Yes ☐ No ☐
Date _____ Time _____ Injury reported to employer ☐ Yes ☐ No Name of Supervisor _____
Description of accident _____
_____
Were you injured? _____ How? _____
Location _____
Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____
Patient taken to _____ Hospital for _____ Treatment
confined to hospital for _____ Days _____ Hours. Name of hospital doctor _____
Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None
Describe _____
Do you have an attorney? ☐ Yes ☐ No Name & Address _____
_____

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's Signature _____ Date: _____

CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of

_____, a minor, do hereby authorize _____
(name of minor) (name of agent)

_____ as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____, 20_____, unless sooner
(month and day)
revoked in writing delivered to the agent(s) noted above.

Date: _____

Signature: _____
(parent/legal guardian/person having legal custody) (circle relationship)

Signature: _____
(parent)