



CASE HISTORY
CONFIDENTIAL INFORMATION FORM

Patients Name _____ Date _____
 Soc Sec # _____ Home Phone () _____ Cell Phone () _____
 Address _____ City _____ Zip Code _____
 E-Mail Address _____
 Age _____ Birth Date ___/___/___ Marital Status: M S W D How Many Children _____
 Occupation _____ Employer _____
 Employer Address _____ Work Phone _____
 Name of Insurance Policy Holder _____ Soc Sec # _____
 Name of Insurance Company _____ Address _____
 Name of Spouse _____ Occupation _____
 Employer _____ Address _____
 Patient's Nearest Relative _____ Address _____
 Phone _____ Referred By _____

Are you here due to injuries suffered in a work accident? _____
 Are you here due to injuries suffered in a Auto accident? _____
 Have you ever had the same or similar condition? _____ If so, when? _____
 Have you lost any days from work? _____ If so, how many? _____
 Have you ever had an operation? _____ If so, when? _____
 Have you had any serious illness? _____
 Have you ever been under chiropractic care before? _____ If so, where? _____
 Female: Are you currently pregnant? Yes No
 Date your last menstrual period began _____

Do You:

| | | | |
|------------------|-----|----|--------------|
| Smoke Cigarettes | Yes | No | Occasionally |
| Drink Alcohol | Yes | No | Occasionally |
| Exercise | Yes | No | Occasionally |
| Take Vitamins | Yes | No | Occasionally |

Do you have a family history of:

| | | |
|---------------|-----|----|
| Heart Disease | Yes | No |
| Cancer | Yes | No |
| Diabetes | Yes | No |
| Other | Yes | No |

Major Complaint _____

How long have you had this condition? _____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM



Do you know what may have caused this condition? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Does your condition interfere with your:

Work Yes No

Sleep Yes No

Daily Routine Yes No

Other _____

Have you seen any other doctor's regarding this condition? (Please specify names and dates)

Are you currently taking any prescriptions or over the counter medications? _____

If so, please list _____

Do you have a regular doctor or someone you consult about maintaining your health? _____

Do you consider yourself a healthy person? Yes No

What positive changes would better health provide for you? _____

Are you interested in learning about how to prevent health problems for yourself and your family?

Yes No

Do you practice healthy eating habits? Always Occasionally Rarely

Are you interested in learning more about nutrition and exercise? Yes No

PAYMENT OF THE FIRST VISIT IN FULL IS REQUIRED

Person responsible for payment _____

Are you insured? Yes No Name of Insurance Company _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from 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 made out to me to be credited to my account. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

Patients Signature _____ Date _____

Guardian or Spouse's Signature authorizing care _____ Date _____

Information taken by _____

