NAME ______________________________ TYPE CASE ______________ DR. ______________

DATE			TIME	DR. INIT.	SUBSEQUENT VISITS, TREATMENTS AND REMARKS
MO	DAY	YR			

SAMPLE

CARD NO. ________ **DATE** ________ **TYPE CASE** ________ **DR.** ________

NAME ________ Marital Status: ☐ M ☐ S ☐ W ☐ D Social Sec. No. ________

Address ________ City ________ Zip ________ Home Phone ________

Age ________ Birthdate ________ Sex ________ No. of children ________ Their ages ________

Occupation ________ Employer ________ Address ________ Phone ________

Mates Employer ________ Address ________

Insurance Carrier ________ Address ________ Policy/Claim No. ________

Subsequent Insurance Carrier ________ Address ________ Policy/Claim No. ________

CASES REFERRED BY THIS PATIENT:

Name & Date ________ Name & Date ________

Name & Date ________ Name & Date ________

Name & Date ________ Name & Date ________

Referred By ________

☐ Exercises: ________

Date attended Spinal Care Class ________

☐ Spouse attended

Date of Report ________

Did Spouse attend? ☐ Yes ☐ No

☐ Multiple Appointments given

☐ Written Report ________

☐ Diet: ________

DIETARY SUPPLEMENTS (List all new supplements given)

Date	Supplements	Date	Supplements

ORTHOPEDIC

Date	Supports	Date	Supports
			LIFTS: L. ______ **R.** ______

X-RAY I.D. NO. ________ Date latest X-Rays taken ________

X-RAY FINDINGS: ________

X-RAYS RELEASED TO: ________ Date ________ Date Returned ________

LABORATORY FINDINGS: ________

AK EXAM ________ **EKG** ________ **VASCULAR STUDIES** ________ OTHER ________

SUBJECTIVE COMPLAINTS: ________

OBJECTIVE FINDINGS: ________

DIAGNOSIS: ________

PROGNOSIS: ________

PRECAUTIONS: ________

SAMPLE

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