CONFIDENTIAL CASE HISTORY

NAME: LAST	FIRST	MIDDLE	SEX	AGE	BIRTH DATE	TODAY'S DATE

STREET ADDRESS	MARITAL STATUS M S W D	WEIGHT	FEMALES — ARE YOU PREGNANT?_____ LMP _____

CITY	STATE	ZIP	SOCIAL SECURITY NO.	OCCUPATION

HOME PHONE	BUSINESS PHONE	REFERRED BY	DRIVER'S LICENSE NO.

NEXT OF KIN	RELATIONSHIP	AUTO ACCIDENT ☐	MEDICARE ☐	MEDI-CAL ☐	BLUE CROSS ☐	WORKER'S COMP. ☐

STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)	OTHER INSURANCE COMPANY	NO COVERAGE ☐

CITY	STATE	ZIP	PHONE	NAME OF INSURED PERSON	IDENTIFICATION NO.

EMPLOYER'S NAME & ADDRESS

STREET ADDRESS

CITY STATE ZIP

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I am financially responsible for non-covered services. I also authorize the physician to release any information required.

Signed (Patient, or Parent, if Minor) _____

Date _____

Why are you seeing the doctor?

_____

_____

_____

This is a new/old illness. It was not/was treated before.

If treated before, what was done? _____

_____

_____

When? _____ By whom? _____

HAVE YOU HAD PROBLEMS WITH THESE? CHECK YES OR NO

	YES	NO		YES	NO
lumps	☐	☐	hearing	☐	☐
moles	☐	☐	seeing	☐	☐
swelling	☐	☐	smelling	☐	☐
stiff joints	☐	☐	racing heart	☐	☐
dizziness	☐	☐	digestion	☐	☐
balance	☐	☐	weight	☐	☐
appetite	☐	☐	constipation	☐	☐
sleeping	☐	☐	mood or feelings	☐	☐
breathing	☐	☐	(women only)		
pains, aches	☐	☐	menstruation	☐	☐
Have you ever had Chiropractic care before?				☐	☐

Have you been X-Rayed before? What parts? _____

_____

Pap smear (women only) Never ☐ Date _____

Chest X-Ray: Never ☐ Date _____

Last medical examination: Never ☐ Date _____

Who is or was your regular doctor?

_____

City & State _____

PATIENT SIGNATURE _____

CHECK IF YOU OR A BLOOD RELATIVE HAVE HAD OR HAVE THESE:

	YOU	BLOOD RELATIVE		YOU	BLOOD RELATIVE
anemia	☐	☐	kidney or bladder trouble	☐	☐
asthma	☐	☐			
bleeding tendencies	☐	☐	mental disorder	☐	☐
cancer or tumor	☐	☐	rheumatism or arthritis	☐	☐
diabetes	☐	☐	stroke	☐	☐
epilepsy	☐	☐	tuberculosis	☐	☐
glaucoma	☐	☐			
gout	☐	☐	ulcer or stomach trouble	☐	☐
heart trouble	☐	☐	numbness	☐	☐
high blood pressure	☐	☐	sciatica	☐	☐
scoliosis	☐	☐	headaches	☐	☐

Are you taking any medication? _____

Specify: _____

_____

How are your dietary/nutritional habits? _____

_____

_____

Do you exercise regularly? _____

Explain: _____

_____

Have you ever had surgery, or been hospitalized?

(Do not count normal births.)

Yes ☐ ☐ No If yes, what year? _____

Where? _____

What was wrong? _____

_____

_____

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CONSULTATION HISTORY

HISTORY OF COMPLAINT (INJURY):

PRESENT COMPLAINTS:

PAST HISTORY:

WORKING DIAGNOSIS:

COMMENTS:

LITIGATION (ATTORNEY):