Chiropractic Case History

Name_____ Preferred Name _____Date_____

Address_____City_____ State_____Zip_____

Date of Birth_____ Phone(_____)_____ Cell / Home

Male / Female Email Address:_____

Main complaint:_____

Location of pain:_____

When did the pain begin and how?_____

Please circle the quality of the pain: dull aching sharp shooting burning throbbing deep nagging other

Does this pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain imaginable)

How frequent is the pain and how long does it last? _____

Do you have a pacemaker/defibrillator? Yes / No

Allergies:_____

Medication:_____

Surgeries:_____

Primary Insurance Company:_____

ID Number:_____ Group: _____

How would you prefer correspondence and/or invoices? Paper Text Email

Do you text as a form of communication? Yes / No

How did you hear about us? (name of family/friend, internet, etc.)_____

AUTHORIZATION FOR EXAMINATION AND TREATMENT

I authorize Dr. Wurtz to administer treatment and examination, performing such general procedures as he deems necessary in the diagnosis and treatment of my condition. I am fully aware that certain procedures such as various therapies will be necessary. My care may or may not include specific manipulation maneuvers. Patient care includes examinations, diagnosis, manipulation and treatment of malpositioned articulations and structures, including treatment of soft tissue injuries for reduction of pain and inflammation. I also authorize Dr. Wurtz to take the necessary X-Rays in order to render proper treatment for my condition.

Fees for services performed in the facility (including copay, coinsurance, and self-pay amounts) are due at the time of service, regardless of how long it has been since your last visit. Payment is required for follow-up appointments. If you have not met your deductible at the time services are rendered, you will be asked to pay the estimated allowed amount designated by your health insurance.

Any account 60 days overdue will be subject to a $25 fee. Accounts over 90 days will be subject to an additional $25 fee.

Cancellations without a 4-hour notice or no-shows are subject to a $50.00 fee to be paid by the patient prior to the next appointment.

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the notice of Privacy Practices, and I have been provided an opportunity to review it.

Signature _____

Print Name_____

Date _____