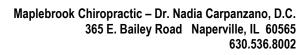




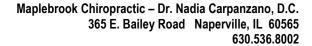
Chiropractic Case History & Patient Information

Personal Information:						
Name:	Home Ph	one: Cell Ph	one:			
Address:						
City/State/Zip:						
E-Mail Address:						
Age: Date of Birth:	Race:	How many children?	Marital: M S W D			
Occupation:	Employer:	Office Phor	ne:			
Spouse:	Occupation:	Employer:				
Family Medical Doctor:						
May we have your permission to	update your medical doctor regarding	your care at this office? () Yes	() No			
Emergency Contact:	Cel	l Phone: Rel	ation:			
Date of Initial Visit:	How did you hear about us?					
Please check any and all insuran	ce coverage that may be applicable in	this case:				
	/orker's Compensation () I ealth Savings Account - HSA () I		() Medicare () Other			
Name of Primary Insurance Comp	oany:	nnce card.				
the doctor to release all informati to secure the payment of benefits	: I authorize payment of insurance ber ion necessary to communicate with pe s. I understand that I am responsible f d or terminate my schedule of care as and payable.	ersonal physicians and other healthca for all costs of chiropractic care, regar	re providers and payors and dless of insurance coverage.			
least a 24-hour notice. Appointm	opractic's 24-hour cancellation policy. ents missed or cancelled with less than we expect to see the patient at the of	an 24 hours can be billed as there are				
payment, healthcare operations, in this office and your rights conconcerning the privacy of your Pa	ees to allow this chiropractic office to and coordination of care. We want yo cerning those records. If you would li atient Health Information we encourag . The following person(s) have my per	u to know how your Patient Health Inf ke to have a more detailed account of le you to read the HIPAA NOTICE that	ormation is going to be used our policies and procedures is available to you at the front			
Patient's Signature:		Date: _				
Guardian's Signature Authorizing	g Care:	Date: _				





Chief Complaint – Purpose of this appointment:						
e symptoms appeared or accident happened: Due To: () Auto () Work () Othe						
Have you ever had the same or a similar condition? () Yes () No	If yes, when and describe:					
Days lost from work: Date of last phy-	sical examination:					
Do you have a history of stroke or hypertension?						
Have you had any major illnesses, injuries, falls, auto accidents, or sur	had the same or a similar condition? () Yes () No If yes, when and describe:					
Have you been treated for any health condition by a physician in the la	st year? () Yes () No					
If yes, describe:						
What medications or drugs are you taking?						
Do you have any allergies to any medications?	() Yes () No					
If yes, describe:						
Do you have allergies of any kind?	() Yes () No					
If yes, describe:						
Do you have a Congenital Condition?	() Yes () No					
If yes, describe:						
[Women] Are you pregnant?	() Yes () No					
SOCIAL HISTORY						
Please indicate beside each activity whether you engage in it: OFTE	N = "O" SOMETIMES = "S" NEVER = "N"					
Vigorous Exercise						
Moderate Exercise						
Alcohol Use						
Tobacco Use						
Caffeine						
High Stress Activity						
Family Pressures						
Financial Pressures						
Other Mental Stresses						





Have you had or do you now have any of the following symptoms/conditions?

Please indicate with the letter $\underline{\mathbf{C}}$ if you have these conditions $\underline{\mathbf{CURRENTLY}}$ or $\underline{\mathbf{P}}$ if you have had these conditions $\underline{\mathbf{PREVIOUSLY}}$.

1.	Headaches	Frequency	31.	Joint Pain/Swelling		
2.	Neck Pain		32.	Menstrual Difficulties		
3.	Stiff Neck		33.	Breathing Problems		
4.	Sleeping Problems			Fatigue		
5.	Back Pain			Lights Bother Eyes		
6.	Nervousness			Ears Ring		
7.	Tension		37.	Broken Bones/Fracture		
8.	Irritability		38.	Rheumatoid Arthritis		
9.	Chest Pains / Tightness		39.	Excessive Bleeding		
10.	Dizziness			Osteoarthritis		
11.	Shoulder/Neck/Arm Pain		41.	Pacemaker		
12.	Numbness in Fingers		42.	Stroke		
13.	Numbness in Toes		43.	Ruptures		
14.	High Blood Pressure			Eating Disorder		
15.	Difficulty Urinating		45.	=		
16.	Weakness in Extremities		46.			
17.	Loss of Balance		47.	Ulcers		
18.	Fainting		48.	Weight Loss/Gain		
19.	Loss of Smell		49.	Depression		
20.	Loss of Taste		50.	Loss of Memory		
21.	Unusual Bowel Patterns		51.	Buzzing in Ears		
22.	Feet Cold		52.	Circulation Problems		
23.	Hands Cold		53.	Seizures/Epilepsy		
24.	Arthritis		54.	Low Blood Pressure		
25.	Muscle Spasms		55.	Osteoporosis		
26.	Frequent Colds		56.	Heart Disease		
27.	Fever		57.	Cancer		
28.	Sinus Problems		58.	Coughing Blood		
29.	Diabetes		59.	Alcoholism		
30.	Indigestion Problems		60.	HIV Positive		
ıve yol	u ever been adjusted before If yes, how long ago?				Yes	No
ould yo	ou be interested in hearing n	nore about therapeutic ma	ssage to help supplement	your Chiropractic Care?	Yes	No
	xplain any condition that you ctor to know.	ı have marked above or a	nything else about your he	ealth history that you think m	ight be im	portant for your