



Case History

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Social Security # _____
 Email _____ Age _____ Birthdate _____ Sex _____ Status: M S W D
 Occupation _____ Employer _____ No. of Children _____
 Employer's Address _____ City _____ State _____ Phone _____
 Spouse's Name _____ Occupation _____ Employer _____
 Person responsible for this account _____ Referred by _____
What is your major complaint? _____

Other complaints _____
 How long have you had this condition? _____ Have you had this or similar conditions in the past? _____
 What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other _____

How long has it been since you really felt good? _____

List Surgical Operations: _____

Are you taking any medications? _____ What kind & for what? _____

Any non-prescription drugs? _____ What kind & for what? _____

OTHER DOCTORS SEEN FOR THIS CONDITIONS: MD DC DO DDS Other

Doctor's Name _____ Diagnosis _____

X-rays _____ Urinalysis _____ Blood Test _____ Other _____

Treatment: Medication _____ Physiotherapy _____

Results _____ Length of time under care _____

Were you off work? _____ If so, how long _____ Have you returned to your same job? _____ If not, why? _____

INSURANCE INFORMATION:

Are you covered by Medicare? Yes No Medicare # _____ State Ins. Aid? Yes No

Do you have any group, union or personal health and accident insurance? Yes No

Name of Insurance Company _____ Claim # _____ Group # _____

Address _____ Phone _____ Agent _____

Additional Insurance Company _____ Claim # _____ Group # _____

Address _____ Phone _____ Agent _____

ACCIDENT INFORMATION:

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No

Date _____ Time _____ Injury reported to employer: Yes No Name of Supervisor _____

Description of accident _____

Were you injured? _____ How? _____

Location of accident? _____

Did you lose consciousness? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____

Patient taken to: _____ Hospital for _____ treatment.

Confined to hospital for _____ Days _____ Hours. Name of hospital doctor _____

Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None

Describe _____

Do you have an attorney? Yes No Name, Address, & Phone _____

I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

Patient Signature _____ Date _____

