Chiropractic Partners

CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION

Date ____________________

Name Last_________________ First ________________MI__ SS # _______-______-_______ Home Phone ___________________

Address_______________________________________ City/State ______________________ Zip Code _______________________

Age_______ Birth Date___________________ Cell Phone _______________ Marital. **M S W D** How Many Children? _________

Occupation_____________________________ Employer ____

Address ____ Office Phone ________________________________

Emergency Contact Name ___________________________ Relationship _______________________ Phone ___________________

How did you hear about our office? ____

Is the condition due to injury or sickness arising out of employment? ____

Is the condition due to injury or sickness arising out of auto or other accident? ____

Days lost from work? __________ Date symptoms appeared or accident happened ____

Have you ever had the same or similar condition? Yes______ No______ If yes, when and describe ____________________________

____ ____

Your medical Doctor ____

Date of last physical examination____

What operations have you had? ____ When? _____________________________

Serious Illnesses? ____ When?_____________________________

- __ Dizziness
- __ Back Aches
- __ Heart Trouble
- __ Diabetes
- __ Tuberculosis
- __ Arthritis
- __ Headache
- __ Numbness
- __ Asthma
- __ Neuritis
- __ Stomach Problems
- __ Nervousness
- __ Sinus Trouble
- __ Anemia
- __ Rheumatic Fever
- __ Cancer
- __ Neck Aches
- __ Hepatitis
- __ Epilepsy
- __ High or Low Blood Pressure
- __ Kidney Problems
- __ Meningitis

Purpose of this appointment ____

Other doctors seen for this condition ____

Have you been treated for any health conditions by a physician in the last year? ( ) YES ( ) NO

Describe ____

What medications or drugs are you taking? ____

HEALTH INSURANCE: ( ) YES ( ) NO COMPANY __________________________ ID # _________________________

Insurance phone number (check back of card) ____________________________ Cardholders DOB ____________________

Patients Signature ____ Date_________________________

Guardian's Signature authorizing care ____ Date_________________________