**ADVANCED CHIROPRATIC AND SPORTS CARE**

1304 GLADE RD STE. 200

COLLEYVILLE, TX 76034

817-428-7246 FAX 817-428-4436

**CASE HISTORY**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_

HOME OR CELL #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECONDARY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DRIVERS LIC. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: M/F

STATUS: S M D W OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSES NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_

INSURANCE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMPLAINTS:**

WHAT IS YOUR MAJOR COMPLAINT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ANY OTHER COMPLAINTS:\_\_\_\_\_\_\_\_\_\_\_\_

HOW LONG HAVE YOU HAD THIS CONDITION:\_\_\_\_\_\_\_\_\_\_\_ HAVE YOU HAD THIS PROBLEM IN THE PAST: Y / N

WHAT ACTIVTIES AGGRIVATE YOUR CONDITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THIS CONDITION CONSTANT: Y / N CONSTANT COMES & GOES DOES THIS CONDITION INTERFER WITH YOUR : WORK SLEEP DAILY ROUTINE WORKOUT OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW LONG HAS IT BEEN SINCE YOU FELT GOOD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST SURGICAL OPERATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS: Y/N LIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANY NON-PRESCRIPTION DRUGS: Y/N LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER DRS SEEN FOR THIS CONDITION: Y / N MD DC DO DDS DRS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTO ACCIDENT INFORMATION:**

DATE OF ACCIDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TIME: \_\_\_\_\_\_\_\_\_\_A.M/P.M LOCATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CLAIM #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADJUSTERS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CARE GIVEN: Y /N IF SO WHAT KIND OF CARE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE AN ATTORNEY: Y / N NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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. OUR STAFF WILL CHECK YOUR INSURANCE COVERAGE AS A COURTESY TO YOU, BUT IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS OF YOUR INSURANCE BENEFITS.

PATIENT NAME DATE