

Case History

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____
PHONE NUMBERS: _____ OR _____
SOCIAL SECURITY #: _____ DRIVERS LIC #: _____
AGE: _____ D.O.B. _____ SEX: _____ STATUS: S M D W #OF CHILDREN: _____
OCCUPATION: _____ EMPLOYER: _____
YRS. EMPLOYEED: _____ EMPLOYER'S ADDRESS: _____
SPOUSE'S NAME: _____ EMPLOYER: _____
PERSON RESPONSIBLE FOR THIS ACCOUNT: _____
EMERGENCY CONTACT: _____ RELATION: _____ PHONE#: _____
REFERRED BY: _____ WHAT IS YOUR MAJOR COMPLAINT: _____
ANY OTHER COMPLAINTS: _____
HOW LONG HAVE YOU HAD THIS CONDITION: _____
HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST: _____
WHAT ACTIVITIES AGGRIVATE YOUR CONDITION: _____
IS THIS CONDITION CONSTANT: YES NO CONSTANT COMES & GOES
DOES THIS CONDITION INTERFERE W/ 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: _____
ANY NON-PRESCRIPTION DRUGS: _____ WHAT KIND: _____
OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS
DOCTOR'S NAME: _____ DIAGNOSIS _____
X-RAYS: _____ URINALYSIS: _____ BLOOD TESTS: _____
TREATMENT MEDICATIONS: _____ PHYSIOTHERAPY: _____
LENGTH OF TIME YOU WERE UNDER CARE: _____ WERE YOU OFF WORK: _____
HOW LONG: _____ HAVE YOU RETURNED TO THE SAME JOB: _____ IF NOT, WHY? _____

WORKERS COMPENSATION INFORMATION

EMPLLOYER: _____ LOCATION: _____
DATE OF ACCIDENT: _____ TIME: _____ SUPERVISORS NAME: _____
DESCRIPTION OF ACCIDENT: _____
CONTACT PERSON OF THE INSURED; NAME: _____ PHONE: _____
LIST TYPE OF EMERGENCY CARE GIVEN: _____

AUTO ACCIDENT INFORMATION

DATE OF ACCIDENT: _____ TIME: _____
LOCATION: _____
LIABILTY INFORMATION; INS.COMPANY: _____
CONTACT PERSON OF THE INSURED; NAME _____ PHONE: _____
DESCRIPTION OF ACCIDENT: _____
LIST TYPE OF EMERGENCY CARE GIVEN: _____
DO YOU HAVE AN ATTOURNEY: YES NO NAME & ADDRESS: _____
PERSONAL INJURY PROTECTION; INS.COMPANY: _____
CONTACT 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.

PATIENTS SIGNATURE

DATE