

**ADVANCED CHIROPRACTIC & SPORTS CARE /
ALLIANCE BACK & NECK CARE**

PATIENT CASE HISTORY:

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____
SS#: _____ DOB: _____ AGE: _____ SEX: _____ M / S / D / W
PHONE #: _____ home/work/cell ALTERNATE #: _____ home/work/cell
EMAIL ADDRESS: _____ EMERGENCY CONTACT NAME, # & RELATION: _____
OCCUPATION: _____ EMPLOYER: _____
YRS EMPLOYED: _____ EMPLOYER ADDRESS: _____
REFERRED BY: _____

WHAT IS YOUR MAJOR COMPLAINT: _____
HOW LONG HAVE YOU HAD THIS CONDITION: _____ ANY OTHER COMPLAINTS: _____
HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST: _____
WHAT AGGRAVATES THIS CONDITION: _____ IS IT CONSTANT: _____
DOES THIS CONDITION INTEREFERE WITH YOUR DAILY LIFE: _____
HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD: _____
OTHER DOCTORS SEEN FOR THIS CONDITION: _____ DIAGNOSIS: _____
LIST YOUR CURRENT PRESCRIPTION MEDICATIONS: _____
CURRENT OVER-THE-COUNTER MEDICATIONS OR SUPPLEMENTS: _____
HAVE YOU HAD XRAY'S OR MRI'S TAKEN: _____
ANY OTHER TESTING: _____ URINALYSIS: _____
BLOOD TESTS: _____ PHYSIOTHERAPY: _____
LENGTH OF TIME YOU WERE UNDER CARE: _____ WERE YOU OFF WORK: _____ HOW LONG: _____
LIST ALL SURGICAL OPERATIONS: _____

WORKERS COMPENSATION:

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

AUTO ACCIDENT – (All auto cases MUST have P.I.P. as office policy):

DATE OF ACCIDENT: _____ TIME: _____ LOCATION: _____
DESCRIPTION OF ACCIDENT: _____
LIST ANY TYPE OF EMERGENCY CARE GIVEN: _____ XRAY'S? _____

PERSONAL INJURY PROTECTION; INSURANCE COMPANY: _____ **CLAIM #** _____
PIP ADJUSTER CONTACT NAME & PHONE: _____

LIABILTY INFORMATION; INS.COMPANY: _____ CLAIM # _____
CONTACT PERSON OF THE INSURED; NAME & # _____
DO YOU HAVE AN ATTOURNEY: YES NO NAME & ADDRESS: _____

*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 RESPONSIBLILTY TO UNDERSATND THE TERMS AND CONDITIONS OF YOUR INSURANCE BENEFITS.)*

Patients Name: _____ **Date:** _____
Signature of Patient OR legal guardian: _____

