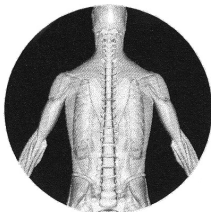
Confidential Patient Case History



Dear Patient,
Please complete this questionnaire.Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactory we will not accept your case. THANK YOU.

Name _____

Address _____

City _____ State _____ Zip _____

Phones - Home: _____ Cell: _____ Work: _____

E-mail Address _____

Age _____ Date of Birth _____ # of Children _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Occupation _____

Spouse's Name _____ Spouse's Date of Birth _____

Referred by _____

Nearest Relative & Telephone _____

Health Information: **Have you had previous chiropractic care?** _____

What is your major complaint? _____

_____

Other complaints _____

Onset of complaint/condition _____

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

Do other family members have similar problems ☐ Yes ☐ No

Please list _____

Others doctors who treated this condition _____

List surgical operations and years: _____

_____

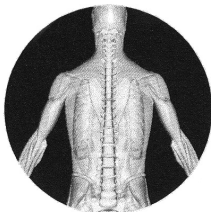
Drugs you now take : ☐ Pain killers ☐ Muscle relaxers ☐ Tranquilizers

☐ Insulin ☐ Birth control pills ☐ Others _____

_____

_____

HOLLISTON SPINE & SPORTS CENTER



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Health Information (continued)

Age of mattress _____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe: _____

_____

Have you had any other personal injury, job related injury or accident? _____

☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe: _____

_____

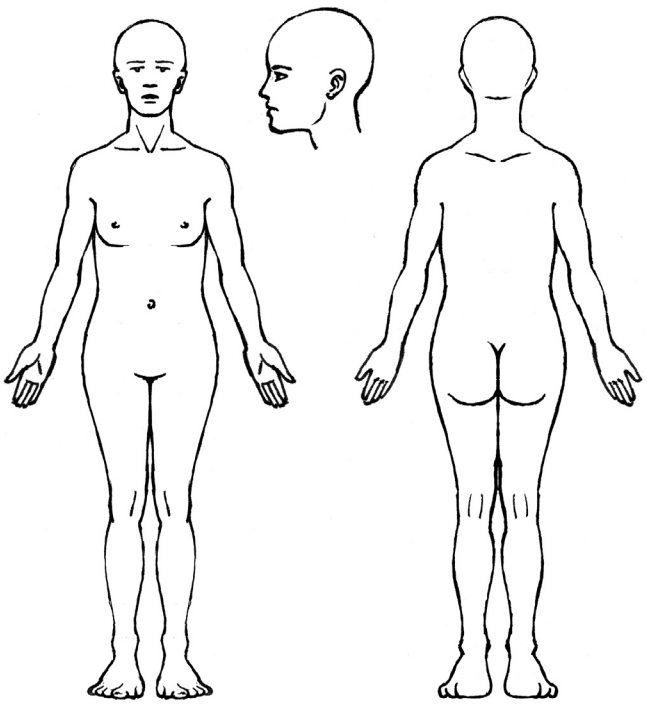
Primary Care Physician _____

Date of last physical examination _____

Family Health Information (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health)

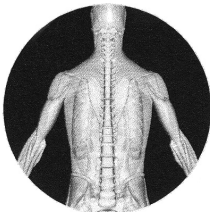
Name	Relation	Past and Present Health Problems

Please mark your areas of pain on figures below:



Have you ever suffered from:

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____



Insurance Information

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Patient's Full Name _____

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐ No

If yes, Name of Company _____ Policy Number _____

Are you covered by Medicare? ☐ Yes ☐ No

If yes, Health Insurance Number _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and 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 me will be due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Thank You

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