BEMIS CHIROPRACTIC CLINIC

Confidential Case History

Patient Name: _____ ❑Male ❑Female Date: _____

Address: _____ Age: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Phone: (H): _____ (W): _____ (Cell): _____

Date of Birth: _____ Marital Status: M S W D Spouse's Name: _____ # Children _____

Occupation: _____ Employer: _____

How did you hear about us? _____

Person Responsible for Account ❑Me ❑Other: Social Security #

Will you be using insurance? ❑No ❑Yes, Insurance Co: _____ (please have us photocopy the card for ID numbers)

Was injury due to Automobile Accident? ❑No If Yes, Auto Insurance:

Have you ever visited a Chiropractor? ❑No If Yes, whom? _____ Time under care: _____ Good Experience? ❑Yes ❑No

Reason for today's visit: _____

Injury? Please describe what happened: _____

_____

When did condition begin? _____ Is it: ❑Constant ? ❑Comes/Goes? ❑Getting Worse?

What makes it worse? _____ Does anything make it feel better? _____

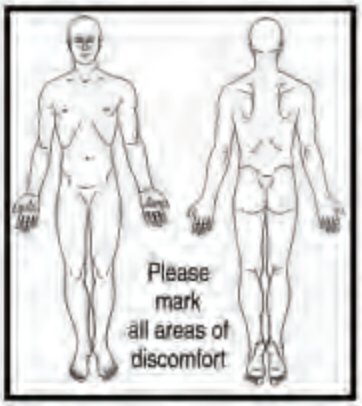
Is it: ❑Burning? ❑Aching? ❑Stabbing? ❑Dull? ❑Radiating, where? _____ ❑Other: _____

Worse in: ❑Morning ❑During Work ❑Evening After Work ❑Middle of Night ❑Other: _____

Have you had this before? ❑No If yes, when? _____ Treatment then: _____

Have you seen any other doctor's recently about this? ❑No If Yes, whom? _____

Have you had recent x-rays? ❑Yes ❑No Females: Are you pregnant? ❑Yes ❑No ❑Not sure



Current Complaints (Present)

❑Headaches	❑Stomach Upset
❑Neck Pain	❑Menstrual Pain
❑Neck Stiffness	❑Ulcers
❑Fatigue	❑Low Back Pain
❑Dizziness	❑Pain Down Leg
❑Numbness	❑Freq Urination
❑Pins&Needles	❑Heartburn
❑Sleeping Prob	❑Other:
❑Depression	_____
❑Cold Hands	_____
❑Irritability	_____

Health History (Past to Present) – Please check all that apply:

❑Heart Disease	❑Pacemaker	❑Irritability
❑Stroke	❑Hepatitis	❑Loss of Weight
❑Immune Disorder	❑Sinus	❑Loss of Sleep
❑High Blood Pressure	❑Arthritis	❑Urinary Problems
❑Joint Replacement	❑Migraines	❑Depression
❑Seizures/Epilepsy	❑Thyroid	❑Fatigue
❑Kidney Disease	❑Asthma	❑Smoke? ____/day
❑Liver Disease	❑Allergies: _____	
❑Diabetes	❑Other: _____	
❑Cancer: _____	❑Other: _____	

Past Surgeries or Hospitalizations: _____

Past Injuries (include auto, work, home, fractures, etc): _____

_____

Medications/Supplements (include presciption/non-prescription): _____

_____

Sleep: usually____hours/night ❑Side ❑Back ❑Stomach Pillows under head: ❑0 ❑1 ❑2

Exercise/Strenuous Hobbies: _____

I authorize release of any information concerning my (or my child's) health care, advice or treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand and agree that all services rendered to me (or my child) are charged directly to me and that I remain personally responsible for payment. I also hereby direct my insurance company to pay this clinic directly for services rendered in accordance with standard assignment of benefits.

_____ _____

Signature of Patient (or parent, if minor) Date