CONFIDENTIAL PATIENT CASE HISTORY

TEAGUE CHIROPRACTIC OFFICE since 1981

Patient Information

Name____SS#______-______-______
Address_____________________________City__________________State_____Zip________
Marital Status: Married _____Single _____Widowed _____Divorced ____Separated_____
Birthdate_________________ Home Phone__________________ Cell Phone__________________
Work Phone________________________ E-mail Address____
Employer ___________________________________ Occupation ____________________________
Emergency Contact___________________________ Phone_______________ Relation____________
Whom may we thank for referring you to us____

Insurance Information – If insured, please provide copy of insurance card

Insurance Name______________________________Policy Holder? Self____Spouse____Parent____
Spouse/Partner/Parents Name ______________________________ Birthdate__________________

SYMPTOMS

Main Complaint________________________________ Constant____Frequent___ Occasionally___
When did it start______________________ Getting Worse___ Getting Better___Staying Same___
Does anything make it better?______________________Worse?______________________________
What time of day is it best?________________________Worse?______________________________
Rate the pain today (0 is pain free – 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10
Secondary Complaint____
Previous Chiropractor/Therapist_____________________ Positive Experience? YES___ NO____
Have you seen another physician for this problem?YES___ NO____Name______________________
Name of local primary Physician_________________________________ Phone_________________

Health History – please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M.S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V.D.	Whooping Cough	
Chronic Fatigue		High Blood Pressure		Fibromyalgia	Other______________________		

Previous Surgeries with dates____
Previous Accidents/Injuries or Falls with dates____________________________________

List ALL Medications you are currently taking_____________________________________
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What kind of exercise do you do____
What supplements do you take____
How much do you smoke per day______________________ Drink per week__________________

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that insurance payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed this office.

Patient Signature____ Date___________________