CASE HISTORY RECORD
Redebaugh Chiropractic, P.A.
PO Box 689
Nisswa, MN 56468
(218) 963-2944

Name_____ Date_____

Mailing Address_____City_____State____Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Age_____ Birth Date_____ Sex_____ Marital: M S D W Children____

S. S. # _____ Spouse's Name_____

Employer_____ Referred by_____

Name of Insurance Company_____

Policy Holder's Name_____ Policy Holder's Birth date_____

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Major complaints and symptoms (describe in detail) _____

_____

Location and type of pain (in detail) _____

_____

When did you first notice this? _____

Has this happened before? _____ When? _____

Does this interfere with your normal living and work?_____

Any family history of this condition? _____

Was it caused by a strain?_____ Fall?_____ Accident?_____

Automobile accident? _____ Work related?_____ Other?_____

Have you had treatment by another doctor for this?___ Dr's Name_____

Treatment_____ X-rays?_____

Length of time under his/her care?_____ Results?_____

History of: Fractures_____ Surgery_____

Hospitalizations_____

Medications (present)_____ (Previous)_____ Vitamins_____

Comments_____

_____

(Over)

CASE HISTORY RECORD

Have you had **any** difficulty with the follow? Mark those that apply.

Head: Headaches_____ Dizziness_____ Sinus_____ Other_____

Eyes: Glasses/Contacts_____ Pain_____ Inflammation_____ Other_____

Ears: Hearing_____ Ringing_____ Wax accumulation_____ Pain_____ Other____

Nose: Smell_____ Hayfever_____ Head colds_____ Obstruction_____

Throat: Speech_____ Tightness_____ Pain_____ Thyroid____ Tonsils____ Other____

Neck: Stiffness_____ Grating_____ Pain_____ Tension_____ Other_____

Right Shoulder: Pain_____ Stiff_____ Bursitis_____ Other_____

Left Shoulder: Pain_____ Stiff_____ Bursitis_____ Other_____

Arms: R____ L____ Elbows: R____ L____ Wrist: R____ L____ Hands: R____ L____

Heart: Pain_____ Spasms_____ Palpitation_____ Attack_____ Other_____

High Blood Pressure:_____ When?_____ **Low Blood Pressure:**_____ When?_____

Lungs: TB_____ Pain around chest_____ Other_____

Abdomen: Stomach_____ Liver_____ Gallbladder_____ Intestines_____

Digestion_____ Gas_____ Constipation_____ Diarrhea_____

Kidneys_____ Hemorrhoids_____ Tenderness of abdomen_____ Other_____

Menstruation: Pain_____ Cramping_____ Irregularity_____ Other_____

Do you have Inner tension?_____ Nervousness_____

Diabetes_____ Cancer_____ Rheumatism_____ Goiter_____

Numbness in any body part_____ Cramps____ Swelling____ Difficulty Sleeping___

Anemia_____ Fainting_____ Weakness_____ Painful joints_____ Swollen joints_____

Arthritis___ Pain in upper back____ Pain in mid back____ Pain in lower back____

Pain in: Hips___ R____ L____ Thigh___ R____ L____ Knee___ R____ L____

Pain in: Calf___ R____ L____ Ankle___ R____ L____ Foot___ R____ L____

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

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for the procedure to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of the office being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition nor for any medical diagnosis.

Patient's Signature_____ Date_____