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 satisfactorily, we will not accept your case.

Whom may we thank for referring you to our office?

ABOUT YOU

Today's Date :_____ File #_____

Name:_____

Home Address:_____

_____

Home Phone #_____ Work #_____

Social Security # _____ Birthdate _____

Marital Status: _ Single __ Married __Separated __Divorced _Widowed

Occupation: _____

Employer's Address:_____

_____

Spouse's Name:_____ #Children_____

DO YOU...

Smoke ☐ No ☐ Yes 1-2-3-4 packs/day

Drink Coffee ☐ No ☐ Yes 1-2-3-4 cups

Drink Tea ☐ No ☐ Yes 1-2-3-4 cups

Drink Diet soda ☐ No ☐ Yes 1-2-3-4

Exercise regularly ☐ No ☐ Yes

Eat a balanced diet ☐ No ☐ Yes

Sleep 8 hours a day ☐ No ☐ Yes

REASON FOR VISIT

Have you ever been to a Chiropractor before?_____ D.C.'s Name _____

Who is your Midwife or Ob/Gyn _____ Phone # _____

The reason for this visit is a result of ☐*Breech presentation* ☐ *backache of pregnancy* ☐ *headache* ☐ *trauma* ☐ *chronic condition* ☐ *other*

_____

How many pregnancies have you had?_____ Vaginal Delivery _____ Cesarean Section _____

Please explain any complications with this or past pregnancies_____

_____

Are you taking any medications and/or vitamins? ☐ Yes ☐ No If Yes, please explain _____

_____

HAVE YOU EVER SUFFERED FROM ...

Dizziness	☐ Before Pregnancy	☐ During Pregnancy
Backaches	☐ Before Pregnancy	☐ During Pregnancy
Water Retention	☐ Before Pregnancy	☐ During Pregnancy
Diabetes	☐ Before Pregnancy	☐ During Pregnancy
High Blood Pressure	☐ Before Pregnancy	☐ During Pregnancy
Headaches	☐ Before Pregnancy	☐ During Pregnancy
Asthma	☐ Before Pregnancy	☐ During Pregnancy
Stomach Trouble	☐ Before Pregnancy	☐ During Pregnancy
Nervousness	☐ Before Pregnancy	☐ During Pregnancy
Sinus Trouble	☐ Before Pregnancy	☐ During Pregnancy
Neck Pain	☐ Before Pregnancy	☐ During Pregnancy
Other	_____	

INSURANCE INFO

Insurance Co. Name: _____

Address: _____

_____

Phone # : _____

Group # (Plan, Local , etc.): _____

Policy #: _____

Plan Name: _____

Insured's SS# : _____

Insured's Name: _____

Relation: _____ Birthdate: _____

Insured's Employer _____

_____

How many weeks gestation is your baby? _____

When is your due date? _____

For Office Use Only:

Patient accepted for care YES / NO
Staff Initials _____ Date _____

Notes

It is our new patient policy that any charges for today will be discussed with you prior to services being rendered. Payment is due upon completion of services today. If your insurance contributes to your care, any insurance payment will be reimbursed to you or credited to your account. If you have any questions, please ask for assistance. Thank You.