

CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Social Security # _____ Driver Lic. # _____
Age _____ Birthdate _____ Sex _____ Status M S W D No. Children _____
Occupation _____ Employer _____ Years Employed _____
Employer's Address _____ City _____ State _____ Phone _____
Spouse's Name _____ Occupation _____ Employer _____
Person responsible for this account _____ Referred by _____

What is your major complaint? _____

Other complaints _____

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 _____

How long has it been since you really felt good? _____

List surgical operations: _____

Are you taking any medications? _____ What kind? _____

Any non-prescription drugs? _____ What kind? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS

Doctor's Name _____ Diagnosis _____

X-rays _____ Urinalysis _____ Blood Tests _____ Other _____

Treatment: Medication _____ Physiotherapy _____

Results _____ Length of time under care _____

Were you off work? _____ If so, how long _____ Have you returned to your same job? _____ If not, why _____

INSURANCE INFORMATION:

Are you covered by Medicare? Yes No Medicare # _____ State Insurance Aid? Yes No

Do you have any group, union or personal health and accident insurance? Yes No

Name of Insurance Company _____ Claim # _____ Group # _____

Address _____ Phone _____ Agent _____

Additional Insurance Company _____ Claim # _____ Group # _____

Address _____ Phone _____ Agent _____

Is your condition due to an accident? illness Other _____

ACCIDENT INFORMATION:

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No

Date _____ Time _____ Injury reported to employer Yes No Name of Supervisor _____

Description of accident _____

Were you injured? _____ How? _____

Location _____

Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____

Patient taken to _____ Hospital for _____ Treatment _____

confined to hospital for _____ Days _____ Hours. Name of hospital doctor _____

Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None

Describe _____

Do you have an attorney? Yes No Name & Address _____

I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

Patient's Signature _____ Date: _____

