

PROPPER

CHIROPRACTIC

CONFIDENTIAL PATIENT CASE HISTORY

(Please print clearly and fill in completely)



PATIENT INFORMATION:

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell phone # _____ e-mail: _____

Occupation _____ Work Phone # _____

Employer (Name & Address) _____

Age _____ Birthdate _____ # of Children _____ Marital Status: (circle) M S W D

Spouse's Name _____ Spouse Phone _____

Referred by _____ Nearest Relative & Phone _____

HEALTH INFORMATION:

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 doctors who have treated this condition: _____

List any current medications: Birth control pills other: _____

List past surgeries and dates: _____

List any auto/work related injuries/accidents & dates: _____

FAMILY HEALTH INFORMATION:

Please list spouse, children, parents & siblings:

Name	Relation	Age	Past and Present Health Status

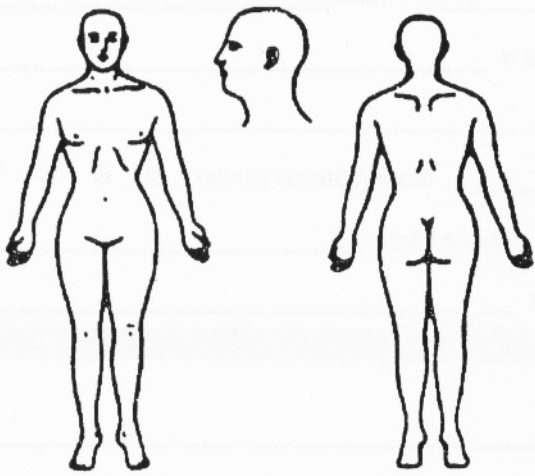
CHIROPRACTIC HISTORY:

Have you ever been to a Chiropractor before? Yes No If yes, Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? Yes No If yes, who? _____

<p>Please mark your areas of pain on the figures below</p> 	<p>Have you ever suffered from:</p> <ol style="list-style-type: none"> 1. Dizziness _____ 2. Headaches _____ 3. Sinus Trouble _____ 4. Heart Conditions _____ 5. Back Pain/Neck Pain _____ 6. Allergies _____ 7. Asthma _____ 8. Nervous Disorders _____ 9. Diabetes _____ 10. Arthritis _____ 11. Digestive Disorders _____ 12. Menstrual Disorders _____
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INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury Yes No

Do you have health Insurance? Yes No If yes,

Name of Company _____ Policy # _____

Policy Holder's Name _____

Policy Holder's Birthdate _____ Employer _____

Are you covered by Medicare? Yes No If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Propper Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Propper Chiropractic will be credited to my account upon receipt. Therefore, I assign my insurance benefits to be paid directly to Propper Chiropractic. However, 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.

I will be paying today by Cash Check Credit Card
 Master Card Visa Card # _____ Exp. Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature: _____ S.S. # _____