LACEY OFFICE □ PINE BEACH OFFICE □ SEAPORT OFFICE □

Confidential Patient Case History

Name_________________________________ Date___________________________
Home Phone #__________________________ Work Phone #____________________
Address_________________________________ City___________________________
State__________ Zip __________ D.O.B. ______________ Age_________________
M_______ F_______ Marital Status_______________ Children___________________
S.S.#_________________________ Driver License #_________________ State______
Employer's Name and Address____
Emergency: Contact____
Phone #__________________________________ Relationship___________________
Spouses Employer and Address____
Health Insurance Primary Carrier____________________________ID#______________
Spouses D. O. B.__________________ Secondary Ins.___________ID#______________
Major Complaint ____
____
Other Complaint____
____
What Improves Your Condition____
____
What Worsens Your Condition____
____
Primary Care
Physician____
Have you had any medical care for this condition?______ If so, what
type?__________________
__________________________Results_____________________________________
Is/Does Your Condition (Circle) Deteriorating Constant Comes and Goes Interfere with: Sleep Your work Daily Routine

Other_____________________________________Have you had some/similar symptoms in the past?__________Explain____
Is there a family history of this condition_____Have you had previous chiropractic care________
If so where____
How did you hear of us____
List previous surgeries and
dates____
____
Medications currently
taking____
____
Do you take birth control pills_________________________What
Type__________________
Are you HIV positive___________________________Breast implants___________________
Do you have an IUD_______________Do you have Norplant___________________________
Person responsible for this
account____

Please check the appropriate space for any of the following symptoms which you now have or have had previously. We need all the facts about your health before we can accept your case.

THIS IS A CONFIDENTIAL REPORT.

__Arthritis	__Gallbladder Trouble
__Bursitis	__Hemorrhoids
__Foot Trouble	__Pain over Stomach
__Hernia	__Excessive Menstrual Flow
__Low Back Pain	__Sore Throat
__Neck Pain/Stiffness	__Asthma
__Pain between shoulders	__High Blood Pressure
__Headache	__Low Blood Pressure
__Loss of Sleep	__Kidney Infection/Stone
__Sciatica	__Painful Menstruation
__Spinal Curvature	__Vaginal Discharge
__Swollen Joints	__Cramps/Backache
__Allergy	__Sinus Infection
__Fatigue	__Hot Flashes
__Dizziness	__Irregular Cycle
__Loss of Weight	__Painful Urination
__Nervousness/Depression	__Prostate Trouble
__Constipation	__Diarrhea

Pain or Numbness in:

__Shoulders	__Arms	__Hands	__Hips
__Legs	__Knees	__Feet	

Check the following conditions you have had:

__Alcoholism	__Diphtheria	__Influenza	__Pneumonia
__Anemia	__Eczema	__Lumbago	__Polio
__Appendicitis	__Emphysema	__Lyme Disease	__Rheumatic Fever
__Arteriosclerosis	__Epilepsy	__Malaria	__Scarlet Fever
__Arthritis	__Fever Blisters	__Measles	__Stroke
__Cancer	__Goiter	__Miscarriage	__Tuberculosis
__Chorea	__Gout	__Multiple sclerosis	__Typhoid Fever
__Cold Sores	__Heart Disease	__Mumps	__Ulcers
__Diabetes	__Hepatitis	__Pleurisy	__Venereal Disease

__Other (explain)____

Date: X-rays__________Blood Test_________Urinalysis__________Spinal Tap__________

NOTICE TO OUR NEW PATIENTS

CHIROPRACTIC SERVICES PROVIDED IN THIS OFFICE ARE PAYABLE THE DAY SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR WITH THE DOCTOR.

INSURANCE CASES

1. Assignments of insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office.
2. Patients are personally responsible for all charges.
3. We will prepare necessary reports to help collect your benefits if an assignment is not taken.
4. By signing below you give us the authority to bill your insurance company directly.

Patient's Signature______________________________

Insured's Signature_________________________________