CASE PRECISION CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION FORM

DATE: _______________ [ ]M [ ]F

NAME: ______________________________ EMAIL: ______________________________

STREET ADDRESS: ______________________________CELL PHONE: ______________________________

CITY/STATE/ZIP: ______________________________ DATE OF BIRTH: _____/_____/_____ AGE: ____________

HOME PHONE: ______________________ WORK PHONE: ______________________ EMPLOYER: ______________________

WORK ADDRESS: ______________________________ OCCUPATION: ______________________________

SOCIAL SECURITY #: ______________________ MARITAL STATUS: [ ]M [ ]D [ ]W [ ]S NUMBER OF CHILDREN: ___________

SPOUSE NAME: ______________________________ SPOUSE EMPLOYER: ______________________________

SPOUSE OCCUPATION: ______________________ PERSON RESPONSIBLE FOR THIS ACCOUNT: ______________________

WHOM MAY WE THANK FOR REFERRING YOU TO US? ______________________________

INSURANCE INFORMATION

NAME OF INSURED:______________________________INSURANCE CO:______________________________

INSURANCE ID#: ______________________ GROUP/CLAIM #: ______________________ POLICY #: ______________________

INSURED SS #: ______________________ INSURED'S BIRTHDATE: ________________ PHONE # OF INS. CO: ______________________

REGARDING INSURANCE AND FEES

PATIENT IS RESPONSIBLE FOR PAYMENT OF ALL SERVICES <u>AT THE TIME SERVICES ARE RENDERED.</u> WE DO RESERVE THE RIGHT TO CHARGE FOR ANY MISSED APPOINTMENT IN WHICH OUR OFFICE DID NOT RECEIVE 24 HOUR NOTICE. AS A COURTESY TO YOU, WE WILL BILL YOUR INSURANCE COMPANY. I AUTHORIZE CASE PRECISION CHIROPRACTIC TO RELEASE ANY INFORMATION REGARDING MY TREATMENT TO MY INSURANCE COMPANY IN EFFORT TO RECEIVE REIMBURSEMENT FOR SERVICES PROVIDED. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

______________________________ ________________ ______________________________
SIGNATURE DATE PARENT (IF PATIENT IS A MINOR)

PAYMENT FOR SERVICES WILL BE BY: [ ] CASH [ ] CHECK [ ] CREDIT CARD

PATIENT CONDITION

DESCRIBE PRESENT COMPLAINTS AND SYMPTOMS IN DETAIL: ______________________________

____

____

IS THIS INJURY THE RESULT OF AN AUTO ACCIDENT OR WORK INJURY? IF SO EXPLAIN: ______________________________

WHEN DID COMPLAINT START?: ______________________HAVE YOU HAD THIS PROBLEM BEFORE?: ____________ IF SO WHEN?: __________

IS CONDITION GETTING WORSE?: ____________ IS PROBLEM: [ ]CONSTANT [ ]FREQUENT [ ]COMES & GOES DESCRIBE: ________________

ON A SCALE OF 0-10 (0 = NO PROBLEM, 10 = SEVERE PROBLEM) HOW WOULD YOU RANK YOUR PROBLEM?: ______________________

WHAT MAKES CONDITION WORSE?: ______________________________

WHAT MAKES CONDITION BETTER?: ______________________________

DOES YOUR CONDITION INTERFERE WITH WORK, SLEEP, DAILY ROUTINE, OR RECREATION? IF SO, DESCRIBE: ______________________

____

OTHER DOCTORS SEEN FOR THIS CONDITION: ______________________________

DIAGNOSIS: ______________________________ TREATMENT RENDERED: ______________________________

RESULTS OF TREATMENT: ______________________________ XRAYS TAKEN: ______________________________

NAME: ______________________________ DATE: ______________

LIST ALL MEDICATIONS AND THEIR PURPOSE: ______________________________
____
PREVIOUS SURGERIES AND DATES: ______________________________
____
LIST ALL PREVIOUS AUTO ACCIDENTS: ______________________________
HOW MANY TIMES HAVE YOU BEEN ON ANTIBIOTICS IN THE LAST 10 YEARS: ______________. LIST ALL NUTRITIONAL SUPPLEMENTS CURRENTLY TAKING: ______________________________
LIST ALL SYNTHETIC OR NATURAL HORMONE REPLACEMENT THERAPY: ______________________________
LIST ALL KNOWN FOOD ALLERGIES: ______________________________
LIST ALL KNOWN ENVIRONMENTAL ALLERGIES: ______________________________

IF YOU ARE HAVING DIFFICULTY WITH THE FOLLOWING, PLEASE CHECK THE BOX:

[ ] HEADACHES	[ ] NECK PAIN	[ ] JAW PAIN	[ ] SHOULDER PAIN	[ ] UPPER BACK PAIN	[ ] MID-BACK PAIN
[ ] LOW BACK PAIN	[ ] DISC INJURY	[ ] DIZZINESS	[ ] HIP PAIN	[ ] ELBOW PAIN	[ ] WRIST PAIN
[ ] KNEE PAIN	[ ] TAILBONE PAIN	[ ] ANKLE PAIN	[ ] FOOT PAIN	[ ] SWOLLEN JOINTS	[ ] MUSCLE SPASMS

HABITS:

DO YOU SMOKE? __________ HOW MUCH? __________ DOES ANYONE SMOKE IN YOUR HOUSEHOLD? __________ DO YOU CONSUME ALCOHOL? __________ HOW MUCH? ______________ DO YOU DRINK COFFEE/CAFFEINE DRINKS? __________ HOW MUCH? __________
DO YOU CONSUME MILK? ________ HOW MUCH? ______________ DO YOU EXERCISE? ________ HOW MUCH? ______________
HOW MANY HOURS OF SLEEP DO YOU AVERAGE PER NIGHT? __________ DO YOU FEEL REFRESHED IN THE MORNING? ______________
HOW MANY HOURS DO YOU WORK A DAY? __________ DO YOU OFTEN FEEL OVERWORKED? ______________________________
HOW MUCH WATER DO YOU DRINK IN A DAY? ______________

FAMILY HISTORY

S=SELF M=MOTHER F=FATHER C=CHILD SP=SPOUSE

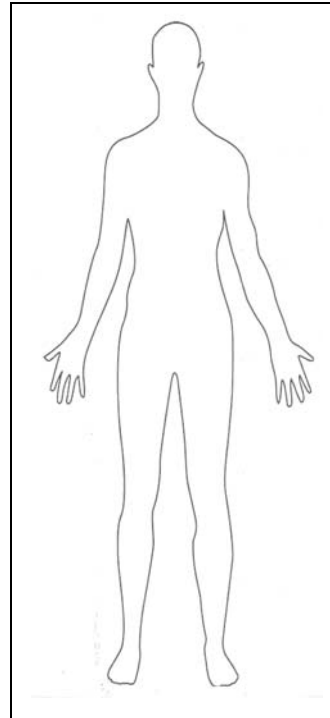
PLEASE INDICATE WHICH CONDITIONS BELOW HAVE BEEN EXPERIENCED BY THE ABOVE USING THE APPROPRIATE LETTER(S).

ALCOHOLISM:	________	ALLERGIES:	________
ANEMIA:	________	ANXIETY:	________
ARTHRITIS:	________	ASTHMA:	________
BACK PAIN:	________	ADD/ADHD:	________
BREAST LUMP:	________	BRONCHITIS:	________
BRUISE EASILY:	________	CANCER:	________
CONSTIPATION:	________	CRAMPS:	________
DEPRESSION:	________	DIABETES:	________
DIGEST. PROB:	________	EYE PROBLEMS:	________
FATIGUE:	________	GERD:	________
GOUT:	________	HEADACHE:	________
HEART DISEASE:	________	HEPATITIS:	________
HI BLOOD PRES:	________	HOT FLASHES:	________
KIDNEY INFECT:	________	KIDNEY STONES:	________
MEMORY LOSS:	________	LOSS OF SMELL:	________
LOSS OF TASTE:	________	LUPUS:	________
MEASLES:	________	MULT.SCLEROSIS:	________
NERVOUSNESS:	________	NOSEBLEEDS:	________
PACEMAKER:	________	POLIO:	________
POOR POSTURE:	________	PROSTATE PROB:	________
SCIATICA:	________	SCOLIOSIS:	________
SHINGLES:	________	SINUS INFECT:	________
SLEEP PROBLEM:	________	STROKE:	________
SWOLLEN JOINT:	________	THYROID PROB:	________
TMJ:	________	TUBERCULOSIS:	________
ULCERS:	________	URINATION PROB:	________
VARICOSE VEIN:	________	VENEREAL DIS:	________
OTHER:	________		

PLEASE USE THE FOLLOWING LETTERS TO INDICATE TYPE AND LOCATION OF THE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING.

A=ACHE B=BURNING N=NUMBNESS S=STABBING
O=OTHER P=PINS AND NEEDLES

FRONT



BACK