FOSSIL CREEK CHIROPRACTIC

CASE HISTORY

☺ We want to Welcome and Thank You for choosing our office ☺

Please print or write legibly:

Name (Last, First, M.I.)_____Date_____

Home Phone _____Cell Phone _____Work Phone _____

Address_____City_____

State_____ Zip_____ SSN# _____Birth date _____Age _____

M / F Single / Marr. / Div. / Other Emergency contact #: _____ Your Email:_____

Employer _____Occupation_____ Referred to us by: _____

Please supply a copy of your insurance card or fill out the following information:

Insured Name_____ Insurance Carrier_____

Birth date_____ Insurance Policy/ID # _____ Phone # _____

Claims Address_____

Claims Adjustor #_____Claim #_____Insurance Group#_____

Family Physician_____

It is our office policy to have your initial examination, consultation and x-rays paid for at the time these services are rendered. If you have questions regarding our policies or need to discuss financial arrangements, please speak with our receptionist. Thank you for choosing our office for your health care needs. For your convenience we have listed several options below from which to choose. Please circle the one you will be using for today's visit:

CASH CHECK CREDIT INSURANCE

Past Chiropractic Care? Yes/No Year____ Doctor's Name _____

For what condition? _____Did you get relief? _____

List your current complaints in order of severity: ***since problem began:***

(1)_____For how long? _____better / worse / same

(2)_____For how long? _____better / worse / same

(3)_____For how long? _____better / worse / same

(4)_____For how long? _____better / worse / same

Circle symptoms that apply:

Headache	Irritability	Shortness of Breath
Neck Pain	Chest Pains	Sleeping Problems
Neck Stiffness	Low Back Pain	Head Feels Heavy
Pins & Needles in Arms	Pins & Needles in Legs	Lightheaded
Numbness in Hands/Fingers	Numbness in Toes	Dizziness

Other _____

CASE HISTORY—Page 2

Name (Last, First, M.I.) _____Date:_____

Is this injury work related? _____ Have you reported it to your employer? _____

Is this injury related to an automobile accident? _____ Does the pain radiate to any other part of your body?_____ What areas? _____

Please list medications you are currently taking?

_____For_____

_____For_____

_____For_____

Please list vitamins and minerals you are currently taking?

_____

_____

PLEASE LIST ALL INJURIES, SURGERIES, ILLNESSES, & CAR ACCIDENTS

AGE 1-10 _____

_____

Age 10-30 _____

_____

Age 30-50 _____

_____

Age 50&Over_____

_____

Family History: Diabetes Heart Disease Cancer Back Pain Headaches

Mother					
Father					
Brother					
Sister					
Grandparents					

Additional Family History:

Patient (or Guardian) Signature: Date: