



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 _____

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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

	Diabetes	Heart Disease	Cancer	Back Pain	Headaches
<i>Mother</i>					
<i>Father</i>					
<i>Brother</i>					
<i>Sister</i>					
<i>Grandparents</i>					

Additional Family History:

Patient (or Guardian) Signature:

Date: