***CASE HISTORY***

Name ______________________________________________

Address ______________ City __________ State ____ Zip __________

Telephone __________ Cell Phone: __________ E-mail: ______________

Social Security # __________ Driver License # ________ Age ___ DOB ________

Sex ___ Status M S W D No. Children ______ Occupation ______________

Employer ______________ Employer's Address ______________________

City ________ State ____ Zip Code _____ Phone ________ Years Employed _____

Spouse's Name __________ Occupation __________ Employer __________

Insurance Policyholder __________________ Policyholder's D.OB. __________

Policyholder's Employer __________________ Referred by ______________

What is your major complaint? ________ How long have you had this condition? __________

Other complaints ______________________________________

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 surgical operations: ______________________________

Are you taking any medications? ________ What kind? ______________________

Any non-prescription drugs? ______ What kind? ______________________

OTHER DOCTORS SEEN FOR THIS CONDITION: __ MD __ DC __ DO __ DDS

Doctor's Name ______________________ Diagnosis ______________

X-Rays ______ Urinalysis ________ Blood Tests ______ Other ____________

Treatment: Medication ______________________ Physiotherapy __________

Results: ____________________ Length of time under care: ____________

Were you off work? ____________ If so, how long? ______________________

Have you returned to your same job? ______ If not, why? ______________________

*****DID YOU HAVE A SPECIFIC ACCIDENT? (i.e. car accident, work injury, slip and fall)*****

Did your accident occur at work? ______ Were you involved in an automobile accident? ______

*** If you answered yes to either please let the staff know if you have not already done so***

I understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one-half percent (1½ % ) per month to any balance owed, and in event of default to pay reasonable collection charges and/or attorney fees. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

**Patient's Signature** ______________________ **Date:** __________