

CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Social Security # _____ Driver Lic. # _____
Age _____ Birthdate _____ Sex _____ Status M S W D No. Children _____
Occupation _____ Employer _____ Years Employed _____
Employer's Address _____ City _____ State _____ Phone _____
Spouse's Name _____ Occupation _____ Employer _____
Person responsible for this account _____ Referred by _____
What is your major complaint? _____

Other complaints _____
How long have you had this condition? _____ 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 _____

INSURANCE INFORMATION:

Are you covered by Medicare? Yes No Medicare # _____ State Insurance Aid? Yes No
Do you have any group, union or personal health and accident insurance? Yes No
Name of Insurance Company _____ Claim # _____ Group # _____
Address _____ Phone _____ Agent _____
Additional Insurance Company _____ Claim # _____ Group # _____
Address _____ Phone _____ Agent _____
Is your condition due to an accident? Illness Other _____

ACCIDENT INFORMATION:

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No
Date _____ Time _____ Injury reported to employer Yes No Name of Supervisor _____
Description of accident _____
Were you injured? _____ How? _____
Location _____
Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____
Patient taken to _____ Hospital for _____ Treatment _____
confined to hospital for _____ Days _____ Hours. Name of hospital doctor _____
Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None
Describe _____
Do you have an attorney? Yes No Name & Address _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that 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: _____

