CONFIDENTIAL PATIENT CASE HISTORY
absolute health chiropractic

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Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond to care, we will not accept your case. Thank You.

Personal Information

Name _____ **Social Security #** _____

Address _____ **City** _____ **State/Zip** _____

Primary Phone _____ **Secondary Phone** _____

E-mail* _____ **Appt. reminder: □ text □ email □ phone call**

Age ____ **Birth Date** _____ **Reported Height** _____ **Reported Weight** _____

Occupation _____ **Referred by** _____

Marital Status: □ M □ S □ W □ D Spouse's Name _____

Spouse's Phone _____ **# of Children** _____

Health Information

Primary Physician Name/Phone # _____

May we contact him/her pertaining to this case? □ Y □ N Signature _____

Have you had previous chiropractic care? □ Y □ N If so, how long ago? _____

What is your major complaint? _____

How long have you had this condition?
□ 1 week □ 2-6 weeks □ 2-4 months □ greater than 4 months
Have you had similar conditions in the past? □ Y □ N If so, how many? _____
Is the condition getting progressively worse? □ Y □ N

What activities aggravate the condition? _____

What makes the condition feel better? _____

Is the condition interfering with: □ Work □ Sleep □ Daily Routine

Other Doctors/Specialists seen for this condition _____

Drugs you now take (prescription ONLY) _____

List any known allergies to any medications _____

Vitamins/Supplements you now take _____

Smoking Status: □ non-smoker □ previous smoker □ 1-3 cigarettes/day □ 1-2 packs/day

□ 2+packs/day □ chewing tobacco □ dipping tobacco

Have you been in an auto accident or had any <u>other</u> personal injury/job related injury?

□ Y □ N If so, describe _____

_____

List any surgical operations and years _____

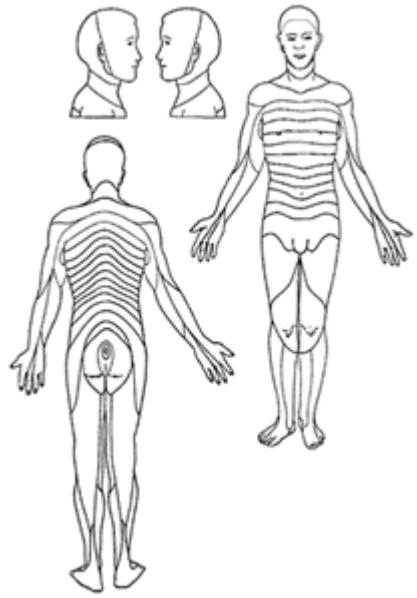
Please check the type of care desired: □ Relief Care □ Corrective Care □ Total Health Care

*Your email address will **not** be sold or re-distributed in any way.
By providing your email address, you will receive periodic informational e-mails from the office and will be enrolled in the Electronic Personal Health Records Program which allows on-line access to medical records.

Health Information (continued)

Please use the letters below to indicate, on the figures, the type and location of your condition right now.

KEY: **A = Aching** **B = Burning** **N = Numbing**
P = Pins and Needles **S = Stabbing** **O = Other**



Other Complaints

Do you suffer from any of the following:

- ☐ **Allergies**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Back Pain**
- ☐ **Diabetes**
- ☐ **Digestive Disorders**
- ☐ **Dizziness**
- ☐ **Headaches**
- ☐ **Heart Trouble**
- ☐ **Hypertension**
- ☐ **Neck Pain**
- ☐ **Nervousness**
- ☐ **Sciatica**
- ☐ **Sinus Problems**

Family History

Many health problems are hereditary; thus information about your family members will give us a better idea for your total health future.

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

Insurance Information

Do you have health insurance? ☐ Y ☐ N **If yes, Name of Company** _____

Policy # _____

Are you covered by Medicare? ☐ Y ☐ N **If yes, Medicare #** _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care plan, any fees for professional services rendered will be immediately due and payable.

I will be paying by: ☐ Cash ☐ Personal Check ☐ Credit Card (Discover, MasterCard, Visa)

Signature _____ **Date** _____