CONFIDENTIAL CASE HISTORY

Date____________________

Please complete this questionnaire. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate healthcare provider. If you need help with this form, please ask our staff.

PERSONAL INFORMATION:

Name ____

How do you wish to be addressed in our office? ❑ First name ❑ Mr ❑ Mrs ❑ Ms ❑ Miss ❑ Dr

Address ______________________________ City ____________________

Zip Code ______________ Birthdate: ____/____/____ Age: __________

Marital Status: ❑ M ❑ S ❑ W ❑ D ❑ Cohabiting

Home Telephone ______________ Business Telephone ______________

Email address: ____

Employer ____________________ Address ____________________

Occupation ______________ Hobbies: What occupies your spare time? ______________

Spouse's Name ______________ Employer ______________ Telephone ______________

Name of nearest relative not living with you ____________________ Telephone ____________

How did you happen to choose our office?

____

HEALTH INFORMATION:

Have you ever been to a chiropractor before?________ What was the problem?____________________

Have you had previous healthcare, for this problem ❑ Yes ❑ No

Where? ____

When? ____

Were x-rays taken? ____

REASON FOR CONSULTING THE OFFICE-please check one:

- ❑ I have a specific problem and require help only with this problem.
- ❑ After my specific problem has been relieved, I am interested in strategies to insure the problem does not return.
- ❑ After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health.
- ❑ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

What is your major complaint? ____

How long have you had this condition? ____

Have you had this or similar conditions in the past? ❑ Yes ❑ No If yes, when? ________________

What activities aggravate your condition? ____

What makes it better? ____

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? ______________________________

Has there been any medical diagnosis of your complaint? ❑ Yes ❑ No If yes, list the Dr.'s name and the

Diagnosis ______________________________

List surgical operations and years: ______________________________

____

List any Prescription Drugs, Over the Counter Drugs, Vitamins and Natural Supplements you now

take: ______________________________

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

Have you been in an auto accident: ❑ Never ❑ Past year ❑ Past 5 years ❑ Over 5 years ago

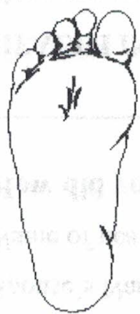
Describe ______________________________

Have you had any other personal injury or accident: ❑ None ❑ Past year ❑ Past 5 years ❑ Over 5 years ago

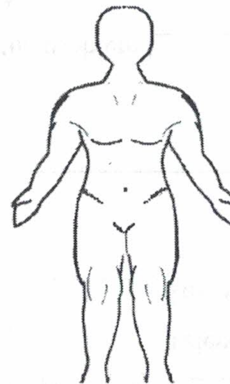
Describe ______________________________

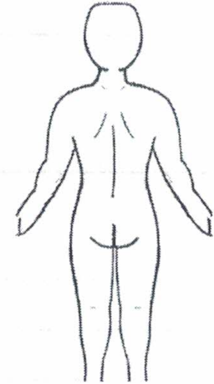
Date of last complete, thorough, physical examination ______________________

Please mark the areas on the figures of Pain or Discomfort:



Right **Left**





Right **Left** **Front** **Back**

Are you affected by any of the following? Please check **O** = Occasionally **F** = Frequently **C** = Constant **N**= Never

O	F	C	N		O	F	C	N		O	F	C	N	
❑	❑	❑	❑	Asthma	❑	❑	❑	❑	Headaches	❑	❑	❑	❑	Dizziness
❑	❑	❑	❑	Backache	❑	❑	❑	❑	Sinus Trouble	❑	❑	❑	❑	High Blood Pressure
❑	❑	❑	❑	Neck Pain	❑	❑	❑	❑	Digestive Upset					*FEMALES ONLY:*
❑	❑	❑	❑	Allergy	❑	❑	❑	❑	Constipation	❑	❑	❑	❑	Painful menstruation
❑	❑	❑	❑	Earache	❑	❑	❑	❑	Heartburn	❑	❑	❑	❑	PMS
❑	❑	❑	❑	Sore Throat	❑	❑	❑	❑	Migraines					Are you pregnant? ❑ Yes ❑ No

We expect that you, personally, will be responsible for all charges. How would you prefer payment?

❑ Cash ❑ Check ❑ Credit/Debit Card

Optional for aiding with insurance paperwork. Your privacy is your own to protect.

SSN# ____________________ Date of Birth ____________

We thank you for your patience and cooperation in completely filling out this form.

Patient's/Guardian's Signature: ______________________________ Date: ____________

Consent to Treatment and Responsibility Agreement

Please read carefully and ***initial*** each section. You may request a copy of this form for your own records.

Patient Name: ____

☐ I, the undersigned, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgment for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of my treatment.

☐ Payment is expected at the time of visit. Any other arrangements, including Retainer plan, direct insurance billing, payment plan or deferral, must be made in advance.

☐ Please notify us if something comes up forcing you to miss an appointment. Our day is scheduled around service to you and others. Notifying us allows us to better use our time to serve the community. Please call (918) 453-9355 and leave a message when canceling appointments.

☐ I hereby authorize the release of my medical records and other information necessary to process any insurance claims and office functions.

☐ I understand that information in my records may be required by law for state agencies for public safety issues such as communicable diseases.

☐ I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, are charged directly to me that I am personally responsible for payment. I understand that even if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

☐ I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, 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.

In addition to the releases outlined above, information may be released to the following individuals/organizations (Put "None" if not applicable):

______________________________ ______________________________

______________________________ ______________________________

X____

Signature (If patient is a minor, signature of parent or legal guardian is required.) Date