

CASE HISTORY

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Cell Phone _____ E Mail Address _____

Social Security # _____ Drivers License # _____ Age _____

Birthdate _____ Sex _____ Status M S W D No. Children _____

Occupation _____ Employer _____ Years Employed _____

Employers' Address _____ City _____ State _____ Phone _____

Spouse's Name _____ Occupation _____ Employer _____

Referred By _____ Person responsible for this account _____

Name of your Insurance Company _____

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 aggravates 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

List surgical operations: _____

List any medications you are taking, if any: _____

Other doctors you've seen for this condition: _____

How long has it been since you really felt good? _____ Is your condition due to an accident? Yes No

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No

Date of Accident _____ Do you have an attorney? Yes No

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 _____

