

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 _____
Home Phone _____ Occupation _____ Work Phone _____
Age ____ Birthdate _____ # of Children ____ E-mail* _____
Marital Status: M S W D Spouse's Name/Phone # _____
Referred by _____ Nearest Relative/Phone # _____

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 _____

Vitamins/Supplements you now take _____

Have you been in an auto accident? Y N If so, describe _____

Have you had any other personal injury, job related injury, or accident? Y N

If so, describe _____

List any surgical operations and years _____

Age of mattress _____ Is it comfortable? Y N

Do you wear any of the following: Heel Lifts Sole Lifts Inner Soles Arch Supports

So that we understand your wishes, please check the type of care desired:

Relief Care Corrective Care Total Health Care I prefer the doctor decides

*Your email address will not be sold or re-distributed in any way. By providing absolute health chiropractic, P.C. with your email address you are agreeing to receive *Absolute News*, absolute health chiropractic's newsletter

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

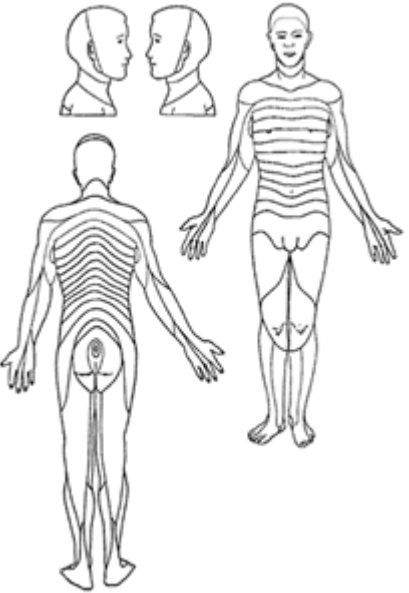
B = Burning

N = Numbing

P = Pins and Needles

S = Stabbing

O = Other

	<p>Other Complaints</p> <p>Do you suffer from any of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back Pain <input type="checkbox"/> Diabetes <input type="checkbox"/> Digestive Disorders <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Hypertension <input type="checkbox"/> Neck Pain <input type="checkbox"/> Nervousness <input type="checkbox"/> Sciatica <input type="checkbox"/> Sinus Problems
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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 # _____

Is your condition due to an auto accident or job-related injury? Y N

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