

CASE HISTORY

Account #: _____

Please complete this form using your keyboard, then print it using the print function of your browser. You can then sign the form and bring it with you to your first appointment. This form will not be submitted via the Internet, so security is not an issue.

Name: _____ Date: _____

Marital Status: Married Single Divorced Widowed

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home) : _____ Phone (Work) : _____

Sex: Male Female Date of Birth: _____ Age: _____ E-mail address: _____

Occupation: _____ Employer: _____

Spouse's Employer: _____ Referred by: _____

Your social security number: _____ Spouse SS#: _____

Have you seen a chiropractor before? Yes No Chiropractor's name: _____

Who is your primary care physician? _____

Reason for your visit today? (Please list areas of pain.) _____

Date of accident or beginning of symptoms: _____

Name of emergency contact or nearest relative not living with you: _____

INSURANCE INFORMATION

Insurance company: _____ Phone: _____

Spouse's insurance company: _____ Phone: _____

Are present symptoms due to an injury? Yes No On the job Auto Accident Personal Injury

Has the accident been reported? Yes No To Worker's Comp? To Auto Carrier?

Have you retained an attorney? Yes No

Name and phone number: _____
