CONCORD CHIROPRACTIC CLINIC

WELCOME TO OUR OFFICE

PATIENT NAME:	CELL #:
ADDRESS:	
CITY/STATE:	zip:
E-MAIL:	
BIRTH DATE:	AGE:SS#:
MARITAL STATUS: S M D W	CHILDREN:
EMPLOYER:	
ADDRESS:	PHONE:
CITY/STATE:	ZIP:
INSURANCE: NOYES	INSURED: SELF/SPOUSE/PARENT
INSURANCE COMPANY:	
INSURED'S INFO IF SPOUSE OR	PARENT
NAME:	BIRTH DATE:
EMPLOYER:	
ADDRESS:	CELL #:
CITY/STATE:	ZIP
procedures and treatments as he may deer my condition. I hereby give my permission by my insurance company. I authorize, ass	and staff to administer and perform such general necessary in the diagnosis and/or treatment of to release any protected information requested ign, and direct my, or any other insurance, e doctor. I understand that I am financially
responsible for any and all non-covered ser event that my account must be turned ove	r to a collection agency because of non-payment, ses (35%) plus attorney's fees and court costs.

CASE HISTORY

On a scale of 1 -10, with 10 being the worst, rate your pain. What makes the pain worse? Is your pain: Constant Intermittent Occasional Describe the pain: Check all that apply. Mild Moderate Severe Stiff Tight Sore Dull Swollen Aching Nagging Burning Sharp Stabbing Shooting Nauseating Radiating Tingling Numb Pins and Needles What relieves the pain? (Please mark areas of pain.) (Please mark areas of pain.) Treatment:	Patient's Name		Date
Date of Onset Sudden Gradual Chief Complaint(s) Traumatic Traumatic Cause Unknown Chief Complaint(s)	CURRENT CONDITIO	N	
Non-Traumatic Traumatic Cause Unknown Chief Complaint(s) Injury: Sports Auto Accident Work-Related Home Describe what happened. On a scale of 1 -10, with 10 being the worst, rate your pain What makes the pain worse? Is your pain: Constant Intermittent Occasional Describe the pain: Check all that apply. Mild Moderate Severe Stiff Tight Sore Dull. Swollen Aching Nagging Burning Sharp Stabbing Shooting Nauseating Radiating Tingling Numb Pins and Needles What relieves the pain? (Please mark areas of pain.) (Please mark areas of pain.) (Please mark areas of pain.) Treatment: Date: Dat	Date of Onset	Sudden _	Gradual
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What relieves the pain?	Shooting Nauses	Magging During_ ating	Charp Ctassing Tingling Numh
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CONCORD CHIRODRACKIC CLINIC CHARM!			
CONCORD CHIROPRACTIC CLINIC - CHART#:	CONCORD CHIROPE	RACTIC CLINIC - CHAR	T#:

CASE HISTORY

MEDICAL HISTORY

Patient Name:	Date:
Previous Chiropractic Care: Conc	dition(s) & Dates Treated?
Current Vitamins/Supplements:	
Medical Diagnoses – Acute or Chi	onic (conditions & dates)
Previous Tests and Dates Perform	ned: (Mark N/A if not applicable.)
X-rays (regions & dates)	
MRI (regions & dates)	
Blood work (type & date)	100000000000000000000000000000000000000
Other Tests (types & dates)	
<u>Significant Health Problems</u> Hospitalizations or ER Visits & D	ates
Surgeries & Dates	
Broken Bones/Dislocations & Dat	tes

CONCORD CHIROPRACTIC CLINIC - CHART#:_____