CONCORD CHIROPRACTIC CLINIC

WELCOME TO OUR OFFICE

WHO MAY WE THANK FOR REFERRING YOU? ____________________

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: NO_____YES______ **INSURED: SELF/SPOUSE/PARENT**

INSURANCE COMPANY: ____

INSURED'S INFO IF SPOUSE OR PARENT

NAME: ________________________________ **BIRTH DATE:** _____________

EMPLOYER: ____

ADDRESS: __________________________________ **CELL #:** _____________

CITY/STATE: __________________________________ **ZIP** _____________

I hereby give my permission to the doctor and staff to administer and perform such general procedures and treatments as he may deem necessary in the diagnosis and/or treatment of my condition. I hereby give my permission to release any protected information requested by my insurance company. I authorize, assign, and direct my, or any other insurance, company benefits to be paid directly to the doctor. I understand that I am financially responsible for any and all non-covered services, deductibles, and co-payments. In the event that my account must be turned over to a collection agency because of non-payment, I agree to pay any and all collection expenses (35%) plus attorney's fees and court costs.

SIGNED: ______________________________________ **DATE:** _______________

CHART#:____________________

CASE HISTORY

Patient's Name______________________________________**Date**_____________

CURRENT CONDITION

Date of Onset_____________________ **Sudden** ________ **Gradual** __________

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**___

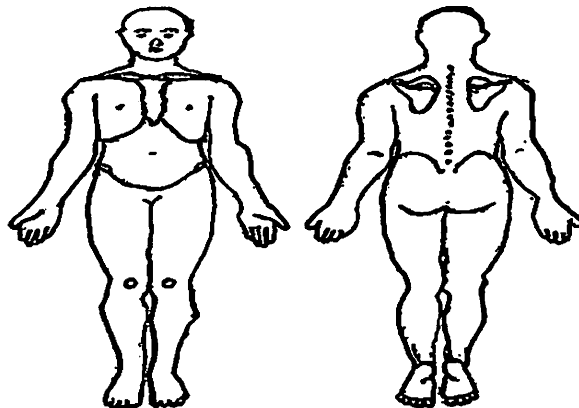
Swollen ____**Aching**___ **Nagging**___ **Burning**___ **Sharp**____ **Stabbing**____

Shooting ____ **Nauseating** ____ **Radiating** _____ **Tingling** ____ **Numb**____

Pins and Needles _____

What relieves the pain?____

(Please mark areas of pain.)



Have been treated for the current complaints? Yes____ **No**____

Doctor's Name:____________________________________**Date:**____________

Treatment:____

Results:____

CASE HISTORY

MEDICAL HISTORY

Patient Name: ________________________________ **Date:**__________

Previous Chiropractic Care: Condition(s) & Dates Treated?

____
____
____
____
____

Current Vitamins/Supplements: ______________________________
____
____
____

Medical Diagnoses – Acute or Chronic (conditions & dates)

____
____
____
____
____

Previous Tests and Dates Performed: (Mark N/A if not applicable.)

X-rays (regions & dates) ____________________________________
____

MRI (regions & dates) ______________________________________
____

Blood work (type & date) ___________________________________
____

Other Tests (types & dates) _________________________________
____

<u>Significant Health Problems</u>
Hospitalizations or ER Visits & Dates ___________________________
____
____
____
____
____

Surgeries & Dates____
____
____
____

Broken Bones/Dislocations & Dates ____________________________
____
____
____