BEACH CHIROPRACTIC CLINIC

CONFIDENTIAL PATIENT CASE HISTORY

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 satisfactorily, we will not accept your case. *Thank you.*

NAME _____ Social Security #_____ DATE _____

How do you prefer to be addressed? ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ First Name ❑ Nickname _____

MAILING ADDRESS CITY STATE ZIP

PERSONAL STREET ADDRESS CITY STATE ZIP

HOME PHONE CELL PHONE WORK PHONE

E-MAIL ADDRESS OCCUPATION EMPLOYER

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: S M W D

PHYSICIAN _____ DENTIST _____

EMERGENCY CONTACT _____ PHONE _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY: ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ INSURANCE

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE _____

CURRENT REASON FOR CONSULTING THIS OFFICE? _____

❑ I have a problem and I am interested in help with this specific problem; in addition, I am interested in learning about the role of WELLNESS in improving my own and my family's health.

❑ I have a problem and I am interested in help with this specific problem and in learning how to prevent it in the future.

❑ I have a problem and I am only interested in help with this specific problem.

HEALTH INFORMATION

Have you had previous chiropractic care? ❑ Yes ❑ No When? _____

Where? _____ Why? _____ Were X-Rays taken? ❑ Yes ❑ No

WHAT IS YOUR MAJOR COMPLAINT? _____

What are your secondary complaints? _____

When did it start? _____ How did it start? _____

What makes it feel better? _____ Aggravates it? _____

Have you had this in the past or anything similar? _____

Is this condition worse? _____ ❑ Constant ❑ Varies

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine

How long has it been since you felt really well? _____

Continued other side

Other doctors who have treated this condition? ❑ Yes ❑ No

List surgical operations and years _____

Medication taken and reason for taking it _____

Age of mattress _____ ❑ Comfortable ❑ Uncomfortable

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Arch supports

Have you ever been in an automobile accident? ❑ Yes ❑ No When? _____

Date of last physical examination _____

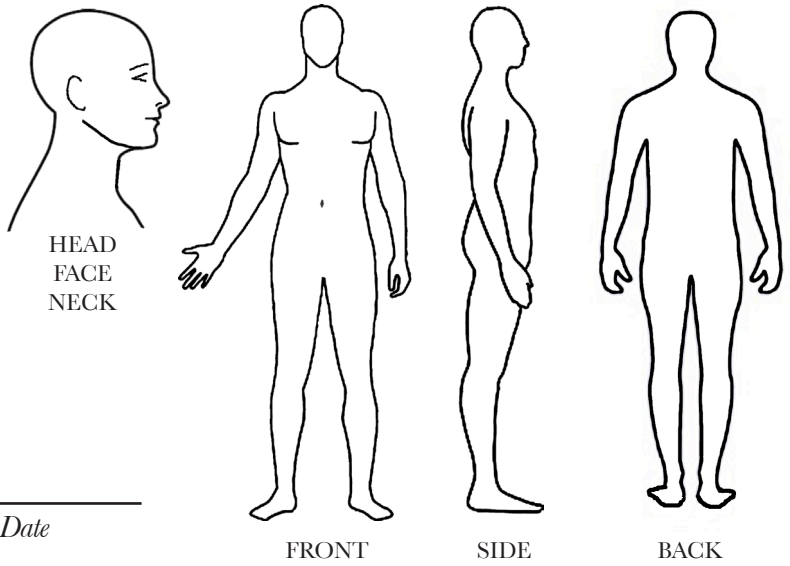
FEMALE HISTORY: Date of last menstrual cycle _____ ❑ Regular ❑ Irregular

Birth control pills: ❑ Yes ❑ No Are you currently pregnant? ❑ Yes ❑ No

Have you ever suffered from:

- ❑ Dizziness
- ❑ Asthma
- ❑ Backaches
- ❑ Digestive Disorders
- ❑ Heart Trouble
- ❑ Anxiety
- ❑ Diabetes
- ❑ Sinus Trouble
- ❑ Arthritis
- ❑ Neck Pain
- ❑ Headaches
- ❑ Other _____

Please mark your areas of pain on the figures below.



_____ _____

Signature *Date*

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? ❑ Yes ❑ No

Do you have health insurance? ❑ Yes ❑ No

Name of Insurance Company _____ Policy # _____

Are you covered by Medicare? ❑ Yes ❑ No

If yes, Medicare "Pat B" ID# _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Beach Chiropractic Clinic 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 *Beach Chiropractic Clinic* will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and 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 me will be immediately due and payable. Any costs related to collection of an unpaid balance including court costs, will be the responsibility of the patient.

Patient's Signature _____ *Date* _____

Guardian or Spouse's Signature _____ *Date* _____