

WELLESLEY CHIROPRACTIC OFFICE

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Case History

PLEASE PRINT CLEARLY

Today's Date (mm/dd/yyyy)			
Patient First Name		Patient Middle Name	Patient Last Name
Name by which you like to be called		Email Address	
Street Address			Apt/Suite
City	State	Zip/Postal Code	Country
Mobile Phone ()	Home Phone ()	Work Phone ()	
Emergency Contact Person	Contact's relationship to you	Emergency Contact Phone ()	
Birth Date (mm/dd/yyyy)	Age	Sex	Social Security Number _____ - ____ - _____
			Marital Status S M D W DP
Occupation		Business/Employer Name	
Spouse/Partner's Name		Your children's Ages	
Who referred you here?		Relationship to you	

The purpose of Chiropractic care is to remove vertebral subluxations to restore normal function to the nervous system and allow your body to express its optimum potential

What is your reason for coming to our office?
Have you had any previous treatment? (describe)
Outcome of treatment

Have you seen a chiropractor before? YES NO		When?
Who?		
How long were you under care?	Reason for stopping care	
Have you ever been hospitalized? YES NO If yes, when and why?		
Have you ever had surgery? YES NO If yes, when and why?		
Do you take any medications (prescription or over-the-counter)? YES NO If yes, please list:		
Please describe any falls, accidents or injuries you have had		
Please list any orthopedic device (orthotics, TMJ appliance, braces, heel lifts, crutches, etc.) you now use or have ever used		
Are you pregnant? YES NO MAYBE	Please add anything else you feel is pertinent to your health	

PLEASE READ AND SIGN THE STATEMENTS BELOW:

PAYMENT AND INSURANCE INFORMATION

If you are here because you have been involved in an accident (automobile, personal or work-related), please notify us immediately and fill out an additional accident information form.

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE

I, [REDACTED] am responsible for payment and I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I clearly understand and agree that all services rendered to me by Wellesley Chiropractic Office are charged directly to me and that 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 to me will be immediately due and payable.

Signature [REDACTED] Date [REDACTED]

Relationship to patient (CIRCLE ONE): SELF SPOUSE PARENT GUARDIAN