# **Case History**

**PLEASE PRINT CLEARLY**

|  |  |  |
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| 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 | | | | | | | |
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| Who referred you here? | | | | | | | | Relationship to you | | | | | | | |
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| **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** | | | | | | | | | | | | | |
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| What is your reason for coming to our office? | | | | | | | | | | | | | | | |
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| Have you had any previous treatment? (describe) | | | | | | | | | | | | | | | |
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| Outcome of treatment | | | | | | | | | | | | | | | |
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| Have you seen a chiropractor before? **YES NO** | | | When? |
| Who? | | |  |
| How long were you under care? | | Reason for stopping care | |
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| Have you ever been hospitalized? **YES NO** If yes, when and why? | | | |
|  | | | |
| Have you ever had surgery? **YES NO** If yes, when and why? | | | |
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| 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? | Please add anything else you feel is pertinent to your health | | |
| **YES NO MAYBE** |  | | |
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| **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, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to patient (CIRCLE ONE): SELF SPOUSE PARENT GUARDIAN |

Case History (2014-06-01)