

Shannon Chiropractic Office
CONFIDENTIAL PATIENT CASE HISTORY

Date: _____

Name: _____ Phone: H: _____ B: _____ C: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Address: _____
Date of Birth: _____ Age: _____ M / F Marital Status: S / M / D / W No. of children: _____ Email: _____
Occupation: _____ Social Security #: _____ Spouse's name: _____
Spouse's Occupation: _____ Work address: _____
Referred by: _____ Hgt. _____ Wgt. _____ Are you R / L handed

Please describe the principal health problems for which you came to this office:

How long have you had the above condition(s):

List any other doctors seen for this:

List any diagnosis(es) and type of treatment(s):

Have you lost any days of work? Y / N if yes, explain:

Have you had similar problems or injuries before? Y / N if yes, explain:

Have you ever fractured any bones? Y / N if yes, explain:

List the names of any relatives that have or have had a similar problem:

Have you received chiropractic treatment previously? Y / N if yes, explain:

Have you been treated for any health condition by a physician in the last year? Y / N if yes, explain:

Are you currently under medication? Y / N if so, what kind?:

List the approximate dates of any surgery or unusual diseases you have had:

Please answer each of the questions below by using the following codes: Leave blank if it does not apply.

"O" for Occasionally: "F" for Frequent: "C" for Constant

NERVOUS SYSTEM:

_____ Headaches	_____ Confusion	_____ Loss of Sleep	_____ Recent Weight Gain
_____ Convulsions	_____ Nervousness	_____ Emphysema	_____ Increased Thirst
_____ Paralysis	_____ Depression	_____ Multiple Sclerosis	_____ Belching or Gas
_____ Tremors	_____ Fainting		_____ Colitis
_____ Sweats	_____ Dizziness	GASTRO INTESTINAL:	_____ Colon Trouble
_____ Numbness	_____ Abnormal Skin	_____ Difficult Chewing	_____ Constipation
_____ Hot Flashes	_____ Sensations	_____ Clicking Jaw	_____ Diarrhea
_____ Neuralgia	_____ Allergies	_____ Discolored Stools	_____ Difficult Digestion
_____ Forgetfulness	_____ Fatigue	_____ Recent Weight Loss	

DO NOT WRITE BELOW THIS LINE

Surgery:

Medications:

Accidents:

GASTRO INTESTINAL cont:

- Distension of Abdomen
- Excessive Hunger
- Gall Bladder Trouble
- Hemorrhoids
- Intestinal Worms
- Jaundice
- Liver Trouble
- Nausea
- Pain Over Stomach
- Vomiting
- Vomiting of Blood
- Difficult Swallowing

EYES, EARS, NOSE & THROAT:

- Colds
- Crossed Eyes
- Deafness
- Earache
- Ear Discharge
- Ear Noises
- Enlarged Glands
- Enlarged Thyroid
- Eye Pain
- Eye Strain
- Failing Vision
- Far Sightedness
- Gum Trouble
- Hay Fever
- Hoarseness
- Nasal Obstruction
- Nosebleeds
- Sinus Infection
- Sore Throat
- Tonsillitis

CARDIO-VASCULAR:

- Hardening of the Arteries
- High Blood Pressure
- Low Blood Pressure
- Pain Over Heart
- Poor Circulation
- Rapid Heart Beat
- Slow Heart Beat
- Swelling of Ankles

MUSCULO-SKELETAL:

- Arthritis
- Bursitis
- Foot Trouble
- Hernia
- Low Back Pain
- Neck Pain or Stiffness
- Pain Between Shoulders

PAIN OR NUMBNESS IN:

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful Tail Bone
- Poor Posture
- Sciatica
- Spinal Curvature (Scoliosis)
- Swollen Joints
- Stiff Joints
- Walking Problems

RESPIRATORY:

- Chest Pain
- Persistent Cough
- Difficulty Breathing
- Spitting up Blood
- Spitting up Phlegm
- Wheezing
- Asthma
- Emphysema

SKIN:

- Boils
- Bruise Easily
- Dryness
- Hives or Allergy
- Itching
- Skin Eruptions (Rash)
- Varicose Veins
- Eczema

GENITO-URINARY:

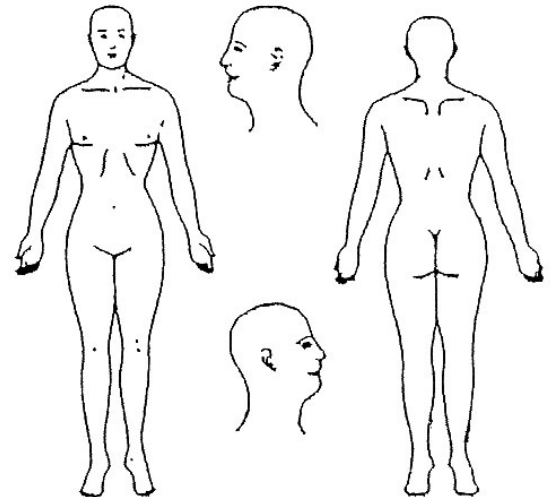
- Bed-wetting
- Blood in Urine
- Frequent Urination
- Inability to Control Kidneys
- Painful Urination
- Prostrate Trouble
- Pus in Urine
- Bladder Trouble
- Diminished Urination
- Discolored Urine
- Venereal Disease

FOR WOMEN ONLY:

Might be Pregnant? Y / N

- Backache with Period
- Cramps with Periods
- Congested Breasts
- Excessive Menstral Flow
- Hot Flashes
- Irregular Cycle
- Lumps in Breast

Please mark your areas of pain on the figures below.



PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of Person responsible for Payment: _____

Are you Insured? Y / N Company: _____ Are you Covered by Medicare? Y / N Is Medicare your primary coverage? Y / N

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office 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 this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me 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. In the event that my account becomes delinquent for more than 90 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all collection costs, court costs, attorney fees and interest fees accrued with the collection of this account.

Signature: _____ Date: _____

(IF PATIENT IS A MINOR, SIGNATURE OF PARENT, GUARDIAN, ETC.)