RESULTS CHIROPRACTIC, LLC

CONFIDENTIAL CASE HISTORY

Name:______________________________ Social Security Number:________________________

Address:______________________________City:___________________State:____Zip:_______

Home/Cell phone:(_____)_____________________Work:(_____)_________________________

Your Employer:____Title:_______________

Age:_______ Date of Birth:___/___/____Marital Status: S W M D No. of Children:____

Email: _____________________________________ Spouse's Name:_______________________

Hobbies: ____

Referred by:____

HEALTH INFORMATION:

Have you had previous chiropractic care? Yes_______ No________

What is your Major complaint?____

Other Complaints:____

How long have you had this condition?____

What activities aggravate this condition?____

Is this condition getting progressively worse? Yes_______ No________

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

How long has it been since you felt really good?____

Other doctors who treated this condition:____

List all surgical operations and their respective years:___________________________________
____
____
____

Do you now take: Nerve pills____ Pain Killers____ Muscle Relaxers____ Insulin____
Tranquilizers:____ Birth Control:____ Other:_________________

Do you sleep on a waterbed? Yes_____ No______

Do you wear: Heel lifts? Y / N Sole Lifts Y / N Arch Supports Y / N

Have you been in an auto accident? If so, when:_____________________________________
Describe:____

Have you had any other personal injury? If so, when:_________________________________
Describe:____

Date of last physical:____

Have you ever suffered from:

- Dizziness Yes No
- Backaches Yes No
- Heart problems Yes No
- Diabetes Yes No
- Arthritis Yes No
- Headaches Yes No
- Asthma Yes No
- Digestive Disorder Yes No
- Nervousness Yes No
- Sinus problems Yes No
- Neck Pain Yes No
- Other_____________________
  ____

Is your condition due to an auto accident or job related injury? Yes_____ No______

Do you have health insurance? Yes______ No_______

-If your **spouse** is the **insured person** then please include their **SSN**:_______________

D.O.B.___/____/______
Employer:_______________________________________

Name of Insurance Company:____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Results Chiropractic, LLC will prepare any necessary reports and/or forms to assist me in making collection from the insurance carrier and that any amount authorized to be paid directly to Results Chiropractic, LLC 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 treatment of terminate my care, any fees for professional services rendered me can be made immediately due and payable at the sole discretion of the doctor.

Patient's Signature:____________________________________Date:_____/______/________

Doctor's Signature____________________________________Date:_____/______/_________

FAMILY HEALTH INFORMATION:
Many health problems are a result of hereditary spinal weaknesses; thus information about your family members will give us a clearer picture of your total health.

NAME RELATION PAST/PRESENT CONDITIONS

____

____

Patient's Signature:____Date_____/_____/_______

RCC.CASE.HIST