Warren Chiropractic Patient Case History

Please answer all questions fully

Patient's Name: _____ Date: _____
Residence Address: _____ City & Zip: _____ _____
Home Phone: _____ Mobile Phone: _____ E-mail: _____
Social Security #:_____ Birthdate: _____ Marital Status: S M D W (circle one)
Your Employer: _____ Occupation: _____
Employer Address: _____ Employer Phone #: _____
Spouse Name _____ EMERGENCY CONTACT:
Spouse Employer: _____ EMERGENCY CONTACT #:

List the reason for your office visit: Injury, Illness, Other. Result of: Auto, Work, Home, Other. (circle one)
Date &Time of Injury/Illness:_____ Brief description of Accident/Injury/Illness/Condition:_____

Weight:_____ Height: _____ Present Complaint: _____

How long have you had this condition? _____ (Females) Are you pregnant? Y N
Have you consulted other doctors for this condition? Y N Give a brief description of treatment: _____

LIST ALL MEDICATIONS BEING TAKEN:_____
List all Current Vitamins/ Nutritional Supplements:_____
Describe any previous Chiropractic care: _____
Doctor's name: _____ Date of last physical: _____ Date of last X-rays:_____

Have You Recently Suffered From Any of the Following:

Whiplash: _____ _____
Headaches/ Dizziness: _____ _____
Neck Pain: _____ _____
Backaches: _____ _____
Chest Pain: _____ _____
Fatigue: _____ _____
Arthritis: _____ _____
Numbness- Arms, legs, hands: _____
Frequent/ Burning urination: _____
Sleeplessness: _____ _____
Constipation/Diarrhea:_____
Shoulder pains: _____ _____
Neuritis/ Bursitis: _____
Asthma: _____ _____
Digestive Disorders: _____ _____
Nervousness: _____ _____
Tension: _____ _____
Anemia: _____ _____
Heart/Blood Pressure Trouble: _____ _____
Rapid/ Irregular Heart Beat: _____
Menstrual irregularities: _____ _____
Male irregularities: _____ _____
Surgeries: _____

Other Health Information: _____

All sales are final on any products and services. No returns

THIS OFFICE IS A NON-INSURANCE PRACTICE. PAYMENTS ARE CASH ONLY.

Fees are payable when service is rendered unless special arrangements are made in advance.
$30.00 charge for every returned check.

**** I consent to treatment of my son/ daughter /myself
Guardian: _____

Cancellation not received 24 hours prior of scheduled appointment may be subject to charge

_____
Patient Signature