W E L C O M E
CASE HISTORY
Thank you for choosing our clinic for your chiropractic needs. Please complete this form fully (PLEASE PRINT!).
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help

NAME:_________________________________ DATE:__________ SOC.SEC#: _______-______-___________
First Middle Last
NAME BY WHICH YOU PREFER TO BE CALLED:_______________________
BIRTHDATE:__________/__________/____________

STREET ADDRESS:_____________________________________
CITY/STATE/ZIP:____

SEX: _____Male _____Female HOME PHONE:________________________ WORK
PHONE:_______________________________

ARE YOU: _____ Married _____Single _____Divorced _____Widowed _____Minor _____Separated

IF MARRIED, SPOUSE S NAME:____________________________ E-MAIL
ADDRESS:______________________________________
(WE WILL USE ONLY TO SEND HEALTH INFO!)
IF EMPLOYED, YOUR EMPLOYER:__________________________
OCCUPATION:____

BUSINESS STREET ADDRESS:_____________________________ IF MINOR, PARENT S
NAME:___________________________

PERSON TO CONTACT IN CASE OF EMERGENCY: _______________________________
PHONE:____________________________

HOW DID YOU HEAR ABOUT US?:

____FRIEND/FAMILY -or- ____DOCTOR REFERRAL PLEASE PROVIDE
NAME:____
_____NEWSPAPER _____MAGAZINE _____PHONE BOOK _____TV _____COUPON _____OTHER

SYMPTOMS
Where are you experiencing your pain/discomfort:____

When did you first notice the symptoms:_______________________ Is condition getting worse?: ___YES___NO

Is the pain constant, or does it come and go: _____Constant _____Comes and Goes

Rate the severity of your pain (1=mild discomfort, 10=severe pain): 1 2 3 4 5 6 7 8 9 10

Which activities are difficult to perform: ___Sitting ___Standing ___Walking ___Bending ___Lying Down

Type of Pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting
___Burning ___Tingling ___Cramps ___Stiffness ___Swelling ___Other

Treatment already received for this condition: ___Medication ___Surgery ___Physical Therapy ___Other
Name of other doctor(s) who has treated you for this condition: ____

INSURANCE AND RESPONSIBLE PARTY INFORMATION

We will ask for a copy of your insurance card(s). We will need the following information:
Name of person through whom insurance is acquired/Responsible Party:_________________________
Birthdate: ______________ Relationship: _____Spouse _____Parent _____Other
Address of responsible party (If not the same as patient s) _____________________________________
(OVER) Street CSZ
HEALTH HISTORY
Check conditions you have had, or currently have:
___AIDS/HIV ___Alcoholism ___Allergy Shots ___Anemia ___Anorexia ___Appendicitis ___Arthritis
___Asthma ___Bleeding Disorders ___Bronchitis ___Cancer ___Chemical Dependency ___Depression ___Diabetes
___Emphysema ___Epilepsy ___Fracture ___Glaucoma ___Goiter
___Gout ___Headaches ___Heart Disease ___Hepatitis ___Hernia ___High Blood Pressure
___High Cholesterol ___Kidney Disease ___Liver Disease ___Miscarriage ___Mononucleosis
___Multiple Sclerosis ___Osteoporosis ___Pacemaker ___Parkinson s Disease ___Pinched Nerve ___Pneumonia
___Polio ___Prostate Problems ___Prosthesis ___Psychiatric Care
___Rheumatoid Arthritis ___Rheumatic Fever ___Scarlet Fever ___Sexually Transmitted Diseases ___Stroke
___Thyroid Problems ___Tonsillitis ___Tuberculosis ___Tumors ___Ulcers
___Other____
____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS FOR ANY OF THESE CONDITIONS: ___YES ___NO

IF SO, WHAT
MEDICATIONS:____
______

ALLERGIES:____
____

LIST ANY TYPES OF SURGERIES, AND DATES THEY TOOK PLACE (YEAR IF THAT S ALL YOU CAN
RECALL):____________

DATE OF LAST VISIT TO ANY
DOCTOR:____

WOMEN: ARE YOU PREGNANT? ___YES ___NO USING ANY FORM OF BIRTH CONTROL?: ___YES ___NO

IF SO, WHAT?:____
DAILY HABITS
WHAT TYPE OF EXERCISE DO YOU PERFORM ON A DAILY BASIS? ___None ___Moderate ___Heavy

WHAT DO YOUR DAILY WORK HABITS INCLUDE? (EX: Sitting, Standing, Light labor, Heavy labor, Computer work)

ARE YOU TAKING ANY NUTRITIONAL SUPPLEMENTS (Including Vitamins): ___YES ___NO

IF YES,
WHAT?:____
____

DO YOU SMOKE?: ___YES ___NO IF YES, HOW MUCH PER DAY?:
____

HOW MUCH LIQUOR DO YOU CONSUME ON A WEEKLY BASIS?:____

HOW MUCH COFFEE OR CAFFEINATED BEVERAGES DO YOU CONSUME ON A DAILY BASIS?:______________________

AUTHORIZATION

I certify that I have read and understand the information listed on these two pages to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor and his/her office staff to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

SIGNATURE OF PATIENT (Or Parent/Guardian if patient is minor) DATE

CONSENT TO TREATMENT OF A MINOR PATIENT:

I hereby authorize Dr. Hayes/London/DeKraker and whomever he/she may designate as his/her assistants to administer treatment as he/she deems necessary to my son/daughter.

X____

SIGNATURE OF PARENT/GUARDIAN WITNESSED BY:

GREENVILLE CHIROPRACTIC CLINIC PHONE: (616) 754-9172 FAX: (616) 754-1067