CASE HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original case history up to date, please provide us with the following information. **PLEASE PRINT**

Name: _____ Date: ___/___/____ Date of Birth: ___/___/_____
Address: _____ City: _____ State: _____ Zip: _____
Telephone (Home): (___)___-_____ (Office): (____)____-_____ (Cell Phone): (____) ____- _____

SS # _____-_____-_____

1. Is your visit to this clinic in reference to an accident? _____ Yes _____ No
   If Yes, was it: _____ Work Comp _____ Automobile _____ Personal Injury _____ Other

_____

_____

2. List present complaints (describe fully):

_____

_____

_____

3. Duration of present condition: _____What do you believe caused this condition:

_____

4. Describe any falls, surgery and/or accidents since last visit:

_____

_____

5. Date of last physical: _____ Date of last adjustment: _____

6. Since your last office visit here, have you consulted another Doctor: _____ Yes _____ No
If so, please give the Doctor's name: _____
And condition for which you were treated: _____
7. What type of treatment did you receive: _____
8. What medications or drugs are you taking? _____
9. Other information the Doctor should know regarding this condition: _____

_____

INSURANCE DATA – Clinic policy requires payment arrangements be made on first visit.
Name of persons responsible for payment: _____Telephone #_____
Do you have insurance? _____ No _____ Yes Company: _____
Please list all sources of insurance: Employee ID # _____
_____ Group Insurance _____ Policy # _____
Name
_____ Spouse's Insurance _____Group # _____
Name
_____ Worker's Comp. _____

_____ Other _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance co. and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree tat all services rendered 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 me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ **Date:**_____

Guardian/Spouse's Signature Authorizing Care_____ Date:_____