CHIROPRACTIC CASE HISTORY

Name:_____
Last First M I
Address:_____

Phone:_____ Cell:_____

Email Address: _____ Do you use text? Yes ☐ No ☐

Date of Birth: _____ Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Employer:_____

Employer's Address: _____Phone: _____

Nearest Relative: _____Phone: _____

Primary Physician: _____Date of last physical: _____

Purpose of today's appointment: _____

Other doctors seen for this condition: _____

Have you been treated for any health condition by a physician within the last year? Yes ☐ No ☐
Please answer the following questions:

1. Is the condition due to an injury arising out of employment? Yes ☐ No ☐
2. Is the condition due to an injury resulting from an auto accident? Yes ☐ No ☐
3. Have you ever had the same or a similar condition? Yes ☐ No☐

If yes, describe:_____

How did you hear about us? Internet ☐ Friend ☐ Postcard or Mailer ☐ Seminar ☐

HEALTH INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between me and my insurance company—not between my insurance company and this office. I authorize Tennessee Spine and Disc to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.
If mine is a regular health insurance case, I agree to pay the allotted percentage/deductibles/co-payments for services as they are rendered. However, I understand that I am ultimately responsible for payment in full, payable to this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating physician, any fees for professional services will be immediately due and payable. **Do you have health insurance?** Yes ☐ No ☐ If yes, name of insurance company: _____ Secondary insurance? Yes ☐ No ☐ If yes, name of secondary insurance: _____ *If you are not the subscriber, we will need to provide the insurance company with the subscriber's information.*

Relationship to Patient: _____

Note: If your medical coverage card states that your medical ID number is your social security number, you will be asked to provide your social security number in order for us to verify coverage information with your insurance company.

Patient's Signature: _____Date: _____

Parent or Guardian's Signature (if applicable): _____Date: _____

Doctor's Use Only:

1. What brings the patient in?

_____

_____

2. How long/how often has he/she had this problem?

_____

_____

3. Has patient had any car accidents, sports injuries or falls in the past that played a role in this?

_____

_____

4. What's a typical day at work like for the patient?

_____

_____

5. What has he/she done to get this corrected?

_____

_____

6. When the pain is at its worst, can he/she tell me what it feels like?

_____

_____

7. I'd like to set up goals for you to see if what we are doing is helping you. Specifically, what are some of the things this pain prevents him/her from doing either partially or completely?

_____

_____

8. Over the past 3 months has the problem gotten better, worse, or is it the same?

_____

_____