

TOBIN FAMILY CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT CASE HISTORY

Welcome to our office!

Please complete this questionnaire. Your answers will help us determine how chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

Name_____

Address_____

Home phone (_____) _____

Work phone (_____) _____

Cell phone (_____) _____

Best day/ time to reach me: _____

...at this number: Cell Home Work

Date of Birth: _____

Social Security # _____ - _____ - _____

Email Address_____

Occupation_____

Marital Status: M S W D

Spouse's Name_____

In case of emergency name & phone #: _____

Your Employer Name/ Address (for insurance): _____

Who may we thank for referring you to our office? _____

HEALTH INFORMATION: Have you had previous chiropractic care? _____

What is your main complaint?_____

How long have you had this condition?_____

Have you had similar conditions in the past?_____

What aggravates your condition?_____

Is this getting progressively worse? Yes No Is this condition: Constant Comes and Goes

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

What are your additional complaints? _____

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

Other doctors who have treated this condition_____

Please list ANY medications (prescription or over-the-counter) that you now take: _____

Vitamins/ Herbs/ Homeopathic Remedies: _____

RELATED HEALTH HISTORY

Have you ever been in an auto accident? YES NO Date(s): _____

Please describe: _____

What types of treatments and/or chiropractic care did you receive to correct any injuries sustained?

Have you ever had any other type of accident (slip & fall, sports injury, childhood injury, etc) _____

PAST MEDICAL HISTORY

Date of last Physical Exam _____ Physician's Name _____

Please list ALL surgeries, major or chronic illnesses, childhood diseases, pregnancies, etc. _____

SOCIAL HISTORY (EXERCISE HABITS, ALCOHOL CONSUMPTION, SMOKING HISTORY) –

* Some health conditions run in families, whether they are the result of genetics or common lifestyle. Information about family members can give us a better understanding of your total health picture.

RELATIONSHIP

HEALTH PROBLEMS

INSURANCE INFORMATION

In order to properly bill insurance claims, we need *all* of the following information:

POLICY HOLDER / INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ EMPLOYER PHONE NUMBER: _____

EMPLOYER NAME AND ADDRESS: _____

Please present your insurance card(s) to the receptionist so that we may verify your chiropractic benefits. We look forward to taking excellent care of your spinal health. THANK YOU!