CURRY CHIROPRACTIC CENTER

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CONFIDENTIAL PATIENT CASE HISTORY

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

Name_____ Social Security #_____

Address_____ City_____ State_____ Zip Code _____

Home Phone _____ Cell Phone _____ Cell Carrier _____

Work Phone_____ Email _____ Marital Status: M S W D

Birthdate_____ Age _____ Spouse's Name_____ # Children _____

Occupation _____ Referred by_____

HEALTH INFORMATION: **Have you had previous chiropractic care?** _____

What is your major complaint? _____

_____

Other complaints?_____

How long have you had this condition? _____ **Have you had this or similar conditions in the past?** ☐Yes ☐No

What activities aggravate your condition? _____

Is this condition getting progressively worse? ○Yes ○No ○Constant ○Comes and goes

Is this condition interfering with your: ◉Work ○Sleep ○Daily routine ○Other_____

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

Other doctors who treated this condition _____

_____

List surgical operations and years: _____

_____

Are you pregnant? _____ **Age of Mattress** _____ ◉Comfortable ○Uncomfortable

Drugs you now take: ○Nerve pills ○Pain killers ○Muscle relaxers ○"Pep" pills ○Tranquilizers
○Insulin ○Birth control ○Others_____

Are you wearing: ○Heels lifts ○Sole lifts ○Inner soles ○Arch support

Have you been in an Auto Accident? ○Past year ○Past 5 years ○Over 5 years ○Never

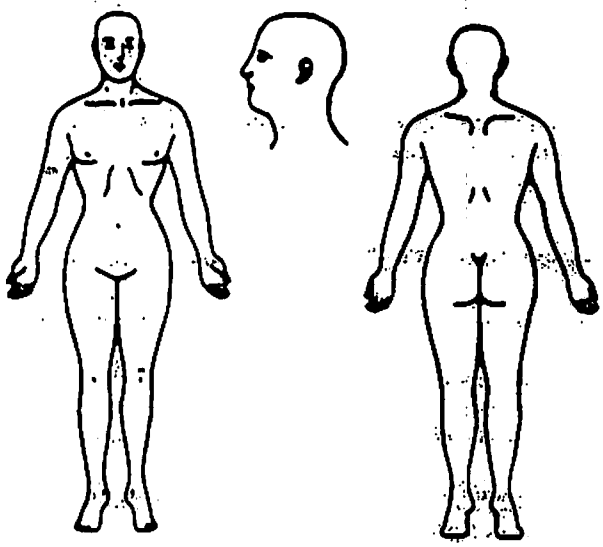
Describe _____

Have you had any other personal injury or accident? ○Past year ○Past 5 years ○Over 5 years ○Never

Describe _____

Date of Last Physical Examination _____

Please mark your areas of pain on the figures below.



Have you Ever Suffered From:

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____ Yes _____ No

Do you have Health Insurance? _____ Yes _____ No If yes,

Name of Company _____ Policy # _____

Are you covered by Medicare? _____ Yes _____ No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that 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.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS