CASE HISTORY ACCIDENT

| Please Print | | _ | | |
|------------------------|---------------------------------|--------------------------------------|------------------|----------------------|
| Patient Name | First MI | I oo Last | iay's Date | |
| Address | | City | State | Zip |
| | Birth date | • | | • |
| | | | | |
| Home phone # | Work pho | Work phone # | | |
| Email address | | | | |
| Check appropriate be | ox: Single Married D | ivorced 🗆 Widowed 🗈 | Separated | Documents |
| Employer | Occupation | | | |
| Spouse's name | His/her employer | | | |
| Referred by: Vello | w Pages Insurance Oth | er | | |
| Have you been to a c | hiropractor before? - No - | Yes, when? | | |
| Person to contact in | | Phone | | |
| Family History – has | any blood relative had any of t | the following: (check if | yes, leave bl | ank if uncertain) |
| | Relationship | | | Relationship |
| □ Back problems | | □ Heart Disease | | |
| □ Cancer | | Migraine Headach | ies | |
| □ Diabetes | | □ Stroke | | |
| □ Epilepsy | | □ Other | | |
| Do you smoke? | lo □ Yes How Much? | | | |
| For women only: Are | e you pregnant? No Yes | | | |
| Check the following of | conditions you have had. | | | |
| □ AIDS/HIV | □ Epilepsy | □ Multiple Scleros | sis 🗆 l | Rheumatoid Arthritis |
| □ Anemia | □ Fractures | □ Osteoporosis | | Appendicitis |
| □ Gout | □ Pacemaker | □ Stroke | | Arthritis |
| □ Heart Disease | □ Parkinson's Disease | | | Back Trouble |
| □ Hepatitis | □ Pinched Nerve | □ Cancer | | Hernia |
| □ Polio | □ Chicken Pox | □ Herniated Disc | | Prostrate Trouble |
| □ Diabetes | □ Migraine Headache | □ Prosthesis | | Other |
| | - i ngi ame i leadache | 1 1 O3CHC313 | | - |

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

Signature Date