

B O Z E M A N
BACK & NECK CLINIC

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CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Date _____
Mailing Address _____ Home Phone _____
Email Address _____ Cell Phone _____
Street Address _____ Zip Code _____
Age ____ Birth Date _____ Marital Status M S W D How Many Children? ____ SS# _____
Occupation _____ Employer _____
Address _____ Office Phone _____
Name of Wife or Husband _____ Occupation _____
Employer _____ Office Phone _____
Patient's Nearest Relative (not living in your household) _____
Address _____
Referred by _____

HEALTH INFORMATION:

Have you had previous chiropractic care? _____
Where? _____
When? _____
Why? _____
Were x-rays taken? _____

What is your MAJOR COMPLAINT? _____

- | | | | | | |
|--|---|--|----|------|---------------------------|
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> ARM PAIN | <input type="checkbox"/> LOW BACK PAIN | Rt | Cent | Lt |
| <input type="checkbox"/> NECK PAIN: | <input type="checkbox"/> UPPER BACK PAIN | <input type="checkbox"/> SACROILIAC PAIN | Rt | LT | |
| <input type="checkbox"/> STIFF NECK | <input type="checkbox"/> MID BACK PAIN | <input type="checkbox"/> LEG PAIN | Rt | Lt | Upper Lower Ant Post Foot |
| <input type="checkbox"/> SHOULDER PAIN | <input type="checkbox"/> RIB PAIN/PAIN ON BREATHING | | | | |

Any other conditions you would like to discuss with the doctor? _____

When did you first notice this condition? _____

Is this visit due to an accident? (ie.: trip, slip, fall, auto accident, hurt on job) _____ Date of Injury? _____

Have you had this or similar conditions in the past? _____ if yes, when? _____

What activities aggravate your condition? _____

What activities relieve your condition? _____

Is this condition getting progressively worse? ____ Yes ____ No ____ Constant ____ Worse with activity

Is this condition interfering with your: ____ Work ____ Sleep ____ Daily life ____ Other

Pain is described as sharp, dull, burning, deep, numbness, tingling, sore, constant, ache, goes from dull to sharp with activity, increased/decreased as the day progresses.

- Other doctors seen for this condition _____
- Surgeries _____
- Medications _____
- Allergies _____
- Past history as it relates to this visit: _____

Other health related issues the doctor should be aware of: _____

Are you wearing? _____ Heel lifts _____ Sole lifts _____ Inner soles _____ Arch supports

Have you been in an auto accident? _____ past year _____ past 5 years _____ over 5 yrs _____ never

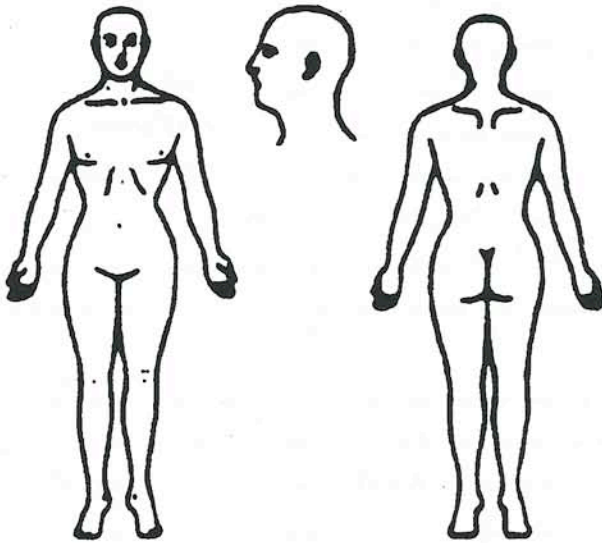
Describe _____

Have you had any other personal injury or accident? _____ past year _____ past 5 yrs _____ over 5 yrs _____ none

Describe _____

Date of Last Physical Examination _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



HAVE YOU EVER SUFFERED FROM:

Dizziness _____

Backaches _____

Heart Trouble _____

Diabetes _____

Arthritis _____

Headaches _____

Asthma _____

Neuritis _____

Digestive Disorders _____

Nervousness _____

Sinus Trouble _____

Neck Pain _____

INSURANCE INFORMATION:

Is your condition due to an auto accident? _____ job related injury? _____

Do you have health insurance? _____ Yes _____ No If yes, please provide following information:

Name of company _____ Policy # _____

Address of company _____

Insured's name _____

Are you covered by Medicare? _____ Yes _____ No If yes, Medicare ID# _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Bozeman Back and Neck Clinic 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 the Bozeman Back and Neck Clinic 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 if a problem arises with payment of my bill and collection / legal services are required, I will be responsible of all costs and legal fees incurred. 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.

PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

Patient' signature _____ Date _____

Guardian's or Spouse's signature _____