



Case History Update

In order for us to best serve you, and so that we may bring your original case history up to date, please provide us with the following information. **PLEASE PRINT**

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone (Home): _____ (Cell): _____ (Office): _____

1. Is your visit to this clinic in reference to an accident? YES _____ NO _____
If yes, was it: Work Comp _____ Automobile _____ Personal Injury _____ Other _____

2. List present complaints (describe fully): _____

3. Duration of present condition: _____ What do you believe caused this condition? _____

4. Describe any falls, surgery, and/or accidents since last visit: _____

5. Date of last physical: _____ Date of last adjustment _____

6. Since your last office visit here, have you consulted another Doctor? YES _____ NO _____
If so, please give the Doctor's name: _____
And condition for which you were treated: _____

7. What type of treatment did you receive? _____

8. What medications or drugs are you taking? _____

9. Other information the Doctor should know regarding this condition: _____

INSURANCE DATA – Clinic policy requires payment arrangements be made on first visit.

Name of persons responsible for payment: _____ Telephone: _____
Do you have insurance? YES _____ NO _____ Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's 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.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____