LIGHTHOUSE CHIROPRACTIC, P.C.
CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this 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.

Date: _____

Name: _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Occupation: _____ Age: _____ Birthdate: _____ Marital Status M S W D

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____ Referred by: _____

Emergency Contact Name: _____ Emergency Contact # _____

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? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes & 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 have treated this condition: _____

_____

List surgical operations and years: _____

_____

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-depressants ☐ Tranquilizers
☐ Insulin ☐ Birth control pills ☐ High Blood Pressure Medicine ☐ Others _____

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 5years
☐ None

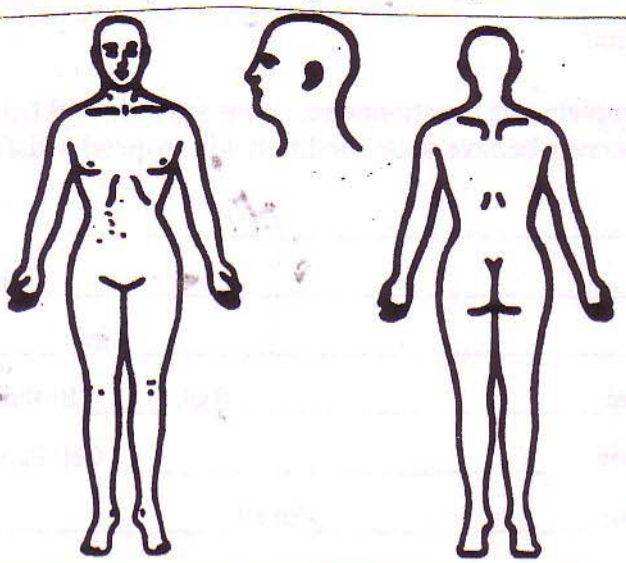
Describe: _____

Date of Last Physical Examination: _____

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 ☐

Please mark your areas of pain on the figure below:



INSURANCE INFORMATION:

Is 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

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.

Patients Signature: _____

Guardian or Spouses Signature: _____ Date: _____

Doctors Signature: _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health. Please provide relevant information, such as name, relationship & health problems:

_____

_____

_____

_____