

HEALTH & WELLNESS CLINIC



CHIROPRACTIC

WELLNESS

Patient Case History

Please complete the questionnaire. Your answers will help us determine how 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 _____
Home Telephone _____ Work Telephone _____ Cell Phone _____
E-Mail Address _____ Birth Date _____ Age _____
Marital Status: M S W D Spouse's Name _____
Emergency Contact person _____ Relationship _____ Phone Number _____
Referred By _____

Health Information:

Have you had previous chiropractic care? _____ When was the last time that you were under chiropractic care? _____
What are your major complaints? _____
Is your condition due to an accident or job related injury? ___ Yes ___ No If yes, provide Auto information in the Insurance section.
How long have you had this condition? _____ Have you had similar conditions in the past? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? ___ Yes ___ No ___ Constant ___ Comes and goes
What other doctors have treated you for this condition? _____
Have you had any other personal injury or accident? ___ Yes ___ No If yes, when _____
How long has it been since you really felt good? _____
List surgical operations and years: _____
Date of Last Physical Examination _____

Medications you take: Nerve pills Pain killers Muscle relaxes Tranquilizer Insulin Birth control

Blood Pressure Medication Others _____

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

Insurance Information: Group Auto Medicare Other

Name of Company _____ Policy / Claim Number _____ Group Number _____

Phone Number _____ Adjuster _____ Ext. _____

ASSIGNMENT OF BENEFITS

I hereby assign from any and all automobile or health or casualty insurance policies which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to **M.K. Murphy, D.C. L.C.**, as Assignee, for services rendered unto me both by reason of accident or illness. This is to act as a limited assignment of my rights and benefits to the extent of the Assignee's services provided and in no way should be construed as a delegation of any duties by the Assignor to Assignee, or a delegation of any conditions precedent under the above referenced insurance policies.

_____ **The Practice's Privacy Notice was made available to me and was posted**

_____ **My health information may be discussed with my spouse/family unless otherwise specified**

Today, I will pay by: Check MC/Visa Cash

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

Guardian Signature if Minor: _____ **Date:** _____