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.
Thank you

NAME______________________________________ AGE___________DOB_______________ SSN_____________________

HOME PHONE____________________CELL PHONE_________________ MARITAL STATUS: S M D W

ADDRESS____CITY_________________________ST______ZIP_________

WK PHONE__________________ EMAIL ADDRESS (for newsletter) ____

OCCUPATION________________________EMPLOYER____

EMPLOYERS ADDRESS ____

SPOUSE'S NAME ________________ WHO REFERRED YOU TO THIS OFFICE ____________________________________

CURRENT HEALTH CONDITION

Have you had previous chiropractic care? ___________

What is your major complaint? ____

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 and 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 treated this condition: ____

Other complaints ____

List surgical operations and years ____

Have you been treated for any health conditions in the last year? Yes ☐ No ☐ Condition ______________________________

____

Drugs you now take: ____

Age of mattress? ________________ Comfortable ☐ Uncomfortable ☐

Are you wearing: Heel lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports ☐

Have you been in an auto accident? Yes ☐ No ☐ Past Year ☐ Past 5 Years ☐ Over 5 years ☐ Never ☐

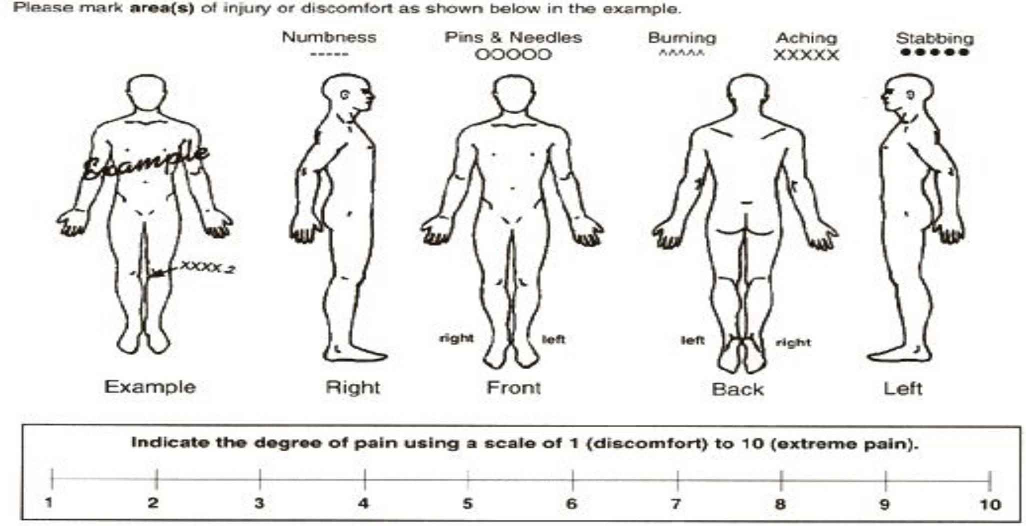
Describe: ____

Have you had any other personal injury or accidents? Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ None ☐

Describe: ____

Date of Last Physical Examination ____

PAST HEALTH HISTORY



Please check any of the following that give you difficulty.

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Loss of balance
- ☐ Blurred vision
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Indigestion
- ☐ Lights bother eyes
- ☐ Pinched nerves in back
- ☐ Allergies/Sinus
- ☐ Twitching of face
- ☐ Nerves and nervousness
- ☐ Tightness of shoulder muscles
- ☐ Menstrual cramps and pain
- ☐ Dizziness
- ☐ Fainting
- ☐ Ringing in ears
- ☐ Indigestion
- ☐ Inflammation of Throat
- ☐ Anemia
- ☐ Intestinal gas
- ☐ Thyroid Trouble
- ☐ Neck pain
- ☐ Grating in neck
- ☐ Loss of memory
- ☐ Mid back pain
- ☐ Heat attacks
- ☐ Cold hands
- ☐ Cold sweats
- ☐ Cold feet
- ☐ Weight loss/gain
- ☐ Low back pain
- ☐ Sleeping problems
- ☐ Diabetic
- ☐ Tightness of throat
- ☐ Depression
- ☐ Pins/needles in legs
- ☐ Pain in shoulders and arms
- ☐ Constipation
- ☐ Kidney Trouble
- ☐ Shortness of breath
- ☐ Chest pains
- ☐ Low blood pressure
- ☐ Stomach trouble
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Pains in legs and feet
- ☐ Swollen ankles
- ☐ Pins/needles in arms and hands
- ☐ Muscle spasms in neck
- ☐ Numbness
- ☐ Asthma
- ☐ High blood pressure
- ☐ Inner tension
- ☐ Irritability
- ☐ Gall bladder trouble
- ☐ Irregularity
- ☐ Cancer
- ☐ Fatigue
- ☐ Stroke

Are you covered by Medicare? Yes ☐ No ☐ If yes, Health Insurance Information_____________________________________

Do you have Health Insurance Yes ☐ No ☐ If yes, name of policy holder ____

Place of Employment of Policy Holder ___________________________________Policy holders Date of Birth _______________

Name of Insurance Company ____Policy Number _________________________

Is this job related? Yes ☐ No ☐ Describe____

Is this condition due to an auto accident? Yes ☐ No ☐ Describe ____

I authorize CRAFT CHIROPRACTIC CENTER to release any information pertinent to my case to my insurance carrier and to submit a claim for all services rendered by this office. I authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to this office for services rendered. I understand I am financially responsible to this office for any balance not covered by this authorization. I understand that if I suspended or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If it is ever necessary for this office to employ collections counsel, I understand that I am responsible for those collection charges. A copy of this signature is as valid as the original.

Patients Signature ____Date _________________

Guardian or Spouse's Signature ____Date _________________

X-RAY CONFIRMATION: This is to confirm that I have been advised by the Craft Chiropractic Center that x-ray can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and consent to spinographic pictures.

Date ______________________________ Signed: ____

CONSENT TO TREAT MINOR CHILD: I hereby authorize the Craft Chiropractic Center to administer chiropractic as deemed necessary to my ____ (indicate relationship to child).

Name of Minor Patient: ______________________________ Date ______________Guardian 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 picture).

NAME	RELATIONSHIP	PAST AND PRESENT HEALTH PROBLEMS

223 Lansing Road, P.O.Box 236, Charlotte, MI 48813 517-543-1115
11653 Hartel Road, Suite 3750, Grand Ledge, MI 48837 517-627-9111
9751 E. Grand River Ave, P.O.Box 367, Portland, MI 48857 517-647-5770
1914 E. Michigan Ave. Lansing, MI 48912 517-487-2225
125 Redfield Plaza, P.O.Box 735, Marshall, MI 49068 269-781-7549