Crafted Care Chiropractic
A walk-in practice that is here for you!

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_____

WORK PHONE_____EMAIL ADDRESS _____

OCCUPATION_____EMPLOYER_____

EMPLOYER'S 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: _____

_____

Medications 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

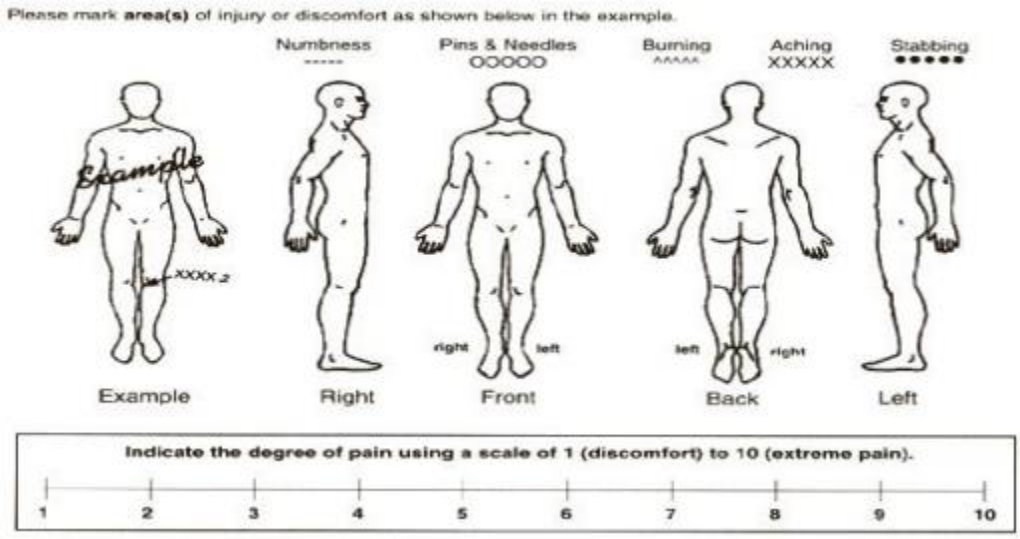
Describe: _____

Have you had any other personal injury or accidents? ☐ Yes ☐ No ☐ 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	☐ Dizziness	☐ Mid Back Pain	☐ Constipation	☐ Numbness
☐ Shooting Head Pains	☐ Fainting	☐ Heat Attacks	☐ Kidney Trouble	☐ Asthma
☐ Loss of Balance	☐ Ringing in Ears	☐ Cold Hands	☐ Shortness of Breath	☐ High Blood Pressure
☐ Blurred Vision	☐ Indigestion	☐ Cold Sweats	☐ Chest Pains	☐ Inner Tension
☐ Loss of Smell	☐ Inflammation of Throat	☐ Cold Feet	☐ Low Blood Pressure	☐ Irritability
☐ Loss of Taste	☐ Anemia	☐ Weight Loss/Gain	☐ Stomach Trouble	☐ Gall Bladder Trouble
☐ Indigestion	☐ Intestinal Gas	☐ Low Back Pain	☐ Swollen Joints	☐ Irregularity
☐ Lights Bother Eyes	☐ Thyroid Trouble	☐ Sleeping Problems	☐ Painful Joints	☐ Cancer
☐ Pinches Nerves in Back	☐ Neck Pain	☐ Diabetic	☐ Pains in Legs and Feet	☐ Fatigue
☐ Allergies/Sinus	☐ Grating in Neck	☐ Tightness of Throat	☐ Swollen Ankles	☐ Stroke
☐ Twitching of Face	☐ Loss of Memory	☐ Depression	☐ Pins/Needles in Arms/Hands	☐ Tightness of Shoulder Muscles
☐ Nerves and Nervousness	☐ Menstrual Cramps/Pain	☐ Pins/Needles in Legs	☐ Muscle Spasms in Neck	☐ Pain in Shoulders/Arms

Are you covered by Medicare? ☐ Yes ☐ No If yes, health insurance information: _____

Do you have health insurance? ☐ Yes ☐ No If yes, name of the policyholder: _____

Place of employment of policy holder: _____Policy holder's 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 CRAFTED CARE CHIROPRACTIC 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 suspend or terminate my care and treatment, any fees for professional services rendered to 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.

Patient's Signature: _____Date:_____

Guardian or Spouse's Signature: _____Date:_____

X-RAY CONFIRMATION: This is to confirm that I have been advised by Crafted Care Chiropractic that X-rays 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 Crafted Care Chiropractic to administer chiropractic as deemed necessary to my _____ (indicate relationship to child).

Name of Minor Patient: _____ Date: _____Guardian's 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