Phipps Chiropractic

Case History

Name_____ Age_____ Date_____ Phone(Cell)_____
Address_____ City_____ State_____ Zip_____
Phone(Home)_____ Date of Birth_____ Sex: M○ F○ Marital Status: S○ M○ D○ W○
Occupation_____ Employer_____ Phone(Work)_____
Email_____

Spouse's Name_____ Spouse's Occupation_____
Spouse's Employer_____ Spouse's Phone(work)_____
Spouse's Phone(Cell)_____

Recommended By_____ Past Chiropractic Care: Yes○ No○ When_____
Result_____ Doctor's Name _____

Emergency Phone Number of Nearest Relative Not Living with You:
Name_____ Phone_____

Chief Complaints:

1._____ Duration(How-Long)_____ Prev. Episodes_____
2._____ Duration(How-Long)_____ Prev. Episodes_____
3._____ Duration(How-Long)_____ Prev. Episodes_____

Are Your Present Problems Due to an Injury: Yes○ No⊙ On the Job○ Auto Accident○ Personal Injury○
Other_____
Are You Now or Have You Ever Been Disabled: Y⊙ No○ When_____
Have You Retained an Attorney: Y○ N⊙ Name/Address_____

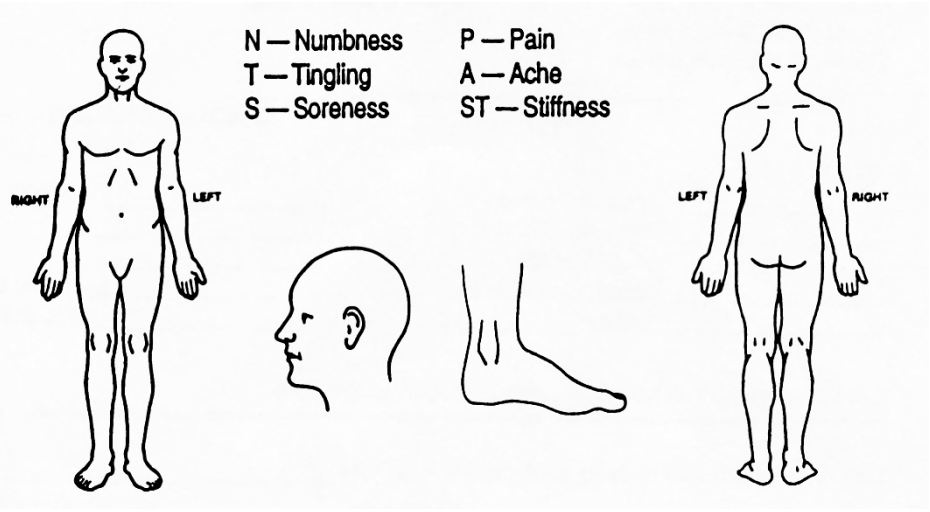
Please Mark the Intensity of Your Pain:
Please Mark the Area/Type of Pain by Using the Code Listed

1- NO PAIN **10 – MOST INTENSE**

1. _____
1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9⊙ 10○

2. _____
1○ 2○ 3○ 4○ 5○ 6○ 7○ 8⊙ 9○ 10○

3. _____
1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9⊙ 10○



DOCTOR'S USE ONLY

_____
_____
_____
_____

Habits:
Smoking Y○ N○ Packs/Day_____
Drinking Y○ N○ Alcohol_____
Coffee Y○ N○ Cups/Day_____

Exercise (select): **NONE**○ **MODERATE**○ **DAILY**○ **Type**:_____

List Any Accidents or Falls:
Car_____ **Sports**_____ **School**_____
Other_____

List Any Broken Bones (Fractures) or Dislocations:_____
Ever On Crutches: Y○ N⊙ Why_____
Spinal Taps or Injections: Y⊙ N○ Were You Ever Knocked Unconscious: Y○ N⊙ Had a Lapse of Memory: Y○ N○
Have You Ever Had X-Rays Taken: Y○ N⊙ When_____ By Whom_____
Why Did You Have the X-Rays Taken_____

Have You Suffered from Other Conditions Not Listed:_____

What Medication (Prescription/Over-the-Counter): Y◯ N◯ What Drugs:_____

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 be credited to my account on receipt. However, I clearly understand and agree that any 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 serviced 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-rays 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/Guardian's Signature X _____ Date_____

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