

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 _____

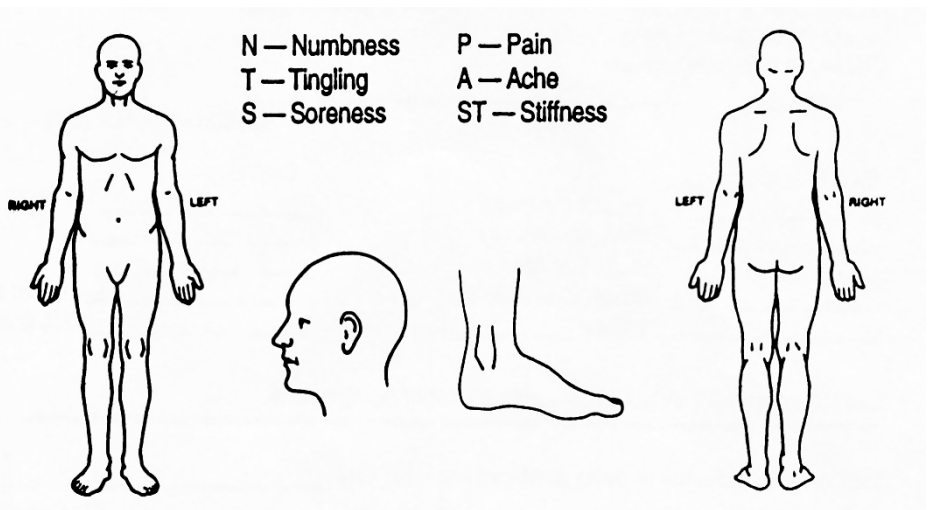
Please Mark the Intensity of Your Pain:
 Please Mark the Area/Type of Pain by Using
 the Code Listed

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: Exercise (select): **NONE** ___ **MODERATE** ___ **DAILY** ___ Type: _____
Smoking Y ___ N ___ Packs/Day _____
Drinking Y ___ N ___ Alcohol _____
Coffee Y ___ N ___ Cups/Day _____
 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 services 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 _____

Medicare Reimbursement Disclosure
Please Read and Sign Below

Medicare pays only for chiropractic spinal manipulations. All spinal manipulations are done at no charge.

Phipps Chiropractic performs examination and/or extra-spinal manipulation and other non-reimbursable services.

Medicare does not pay for examinations or extra-spinal manipulations: (knees, feet, shoulders, hands, elbows, TMJ, ect.)

I fully understand that services provided at Phipps Chiropractic are not reimbursable by Medicare.

x. _____

Date: ____ / ____ / ____