

PATIENT CASE HISTORY

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Social Security no.:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate: / /
Street address:			Cell phone no. ()		Home phone no.: ()	
City:	State:	Zip Code:	May we contact you by email? Email address:			
Occupation:	Employer:			Work phone no.: ()		
Referred by: (name)			Dr.			

What is your major complaint?

Other complaints:

How long have you had this condition? _____ Is this condition getting worse? Yes No Constant intermittent

Is this condition interfering with your: Work Sleep Daily routine Other (please describe)

List surgical operations:

List any prescribed medications you are currently taking:

List any nonprescription medications you are currently taking:

Do you have any medical conditions we should be aware of?

Is your condition related to: Work Auto Other (please describe)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary insurance:		Subscriber's name:		Subscribers ID	Birth date:
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance:		Subscriber's name:		Subscribers ID	Birth date:
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

Have you been treated by a physical/occupational therapist this year? No Yes (last seen & number of visits) _____

Have you been treated by a chiropractor this year? No Yes (last seen & number of visits) _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Cell/Work phone no.: ()
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The above information is true to the best of my knowledge.

Patient/Guardian signature

Date

