

CONFIDENTIAL HEALTH HISTORY

Today's Date _____

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and 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. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Last: _____ First: _____ Middle Initial: _____

Address: _____ Apt. #: _____

City: _____ State _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Ext: _____

Date of Birth: ____/____/____ Age: ____ Sex: M F Height: ____ Feet ____ inches Weight: ____ Lbs.

Occupation: _____ Full / Part Time Employer: _____

Social Security #: _____ - _____ - _____ Person Responsible for Account: _____

Marital Status: M S W D Name of Spouse: _____ Spouses Date of Birth: ____/____/____

Referred By: Another Patient: _____ Insurance Co. Dex Knows Internet Yellow Pages

Previous Chiropractic Care: Yes _____ No _____ If complaint is a result of an injury, check box

Please describe the principal health problems for which you came to this office: _____

Date you first noticed symptoms: _____ How long do the symptoms last? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other _____

List any other doctors seen for this: _____

List any diagnosis(es) and type of treatment(s): _____

Have you lost any days of work? Yes No Dates: _____

Have you had similar accident or injuries before? Yes No If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? Yes No If yes, explain: _____

Are you currently under medication, vitamins, supplements? Yes No If so, what kind? _____

List any surgeries, serious accidents, unusual diseases, or hospitalizations: _____

Please check the type of care desired so that we may be guided by your wishes when possible.

- Nutrition/Supplementation Total Health Care Exercise Control of Immediate Pain
 Weight Reduction I prefer the doctor select the type of care he feels is best for me.

Insurance Information: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Many insurance policies provide chiropractic coverage, but benefits vary from company to company and policy to policy. I understand that Dr. Spresser will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the aforementioned doctor will be credited to my account on receipt. I clearly understand and agree that all 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. We accept certain insurance assignments but all insurance arrangements must be approved in advance by the business office.

Patient's Signature: X _____ Date: _____

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