BACK TO CARE CHIROPRACTIC

Patient Case History
(NOT FOR PERSONAL-INJURY CASE)

Goshtasbi Chiropractic, Inc., dba
Back to Care Chiropractic

INFORMATION ABOUT YOU

Name _____ Email _____

Address _____ City _____ State _____ ZIP Code _____

Phone _____ Social security no. _____ Driver license no. _____

Age _____ Birth date _____ Sex: ❑ M ❑ F Marital status: ❑ M ❑ S ❑ W ❑ D No. of children _____

Occupation _____ Employer _____ No. years employed _____

Employer's address _____ City _____ State ___ Phone _____

Spouse's name _____ Occupation _____ Employer _____

Name of person responsible for this account (if other than self) _____

Surgeries you have had _____

Prescription medications you currently use _____

Non-prescription drugs you currently use _____

Whom may be thank for referring you to us? _____

INFORMATION ABOUT YOUR CONDITION

1. What is your major complaint? _____

   _____

   What other complaints do you have? _____
2. How long have you had this condition? _____ Have you had this or similar conditions in the past? ❑ yes ❑ no
3. What activities aggravate your condition? _____
4. Is this condition getting progressively worse? ❑ yes ❑ no Would you say it ❑ is constant or ❑ comes and goes?
5. Does this condition interfere with ❑ work, ❑ sleep, ❑ daily routine, and/or ❑ other (explain) _____ ?
6. How long has it been since you felt really well? _____
7. **Please list other doctors you have seen for this condition.**

   Name _____ (mark one) MD DC DO DDS/DMD Diagnosis _____

   X-rays _____ Urinalysis _____ Blood tests _____ Other (explain) _____

   Treatment: Medication _____ Physiotherapy _____ Length of time under care: _____

   Results _____

   Name _____ (mark one) MD DC DO DDS/DMD Diagnosis _____

   X-rays _____ Urinalysis _____ Blood tests _____ Other (explain) _____

   Treatment: Medication _____ Physiotherapy _____ Length of time under care: _____

   Results _____

8. Were you off work? ❑ yes ❑ no If yes, how long? _____

   Did you return to the same job? ❑ yes ❑ no If no, why not? _____

9. What caused this condition? ❑ Accident ❑ Illness ❑ Other: _____

10. If condition was caused by an accident, what type? ❑ On-the-job ❑ Automobile ❑ Other: _____

11. If an on-the-job accident, did you report it to your employer? ❑ yes ❑ no Name of supervisor: _____

12. Date and time of accident _____ Description of accident _____

    _____

    Were you injured? ❑ yes ❑ no If yes, how? _____

    Location _____

    Fractures _____ Cuts and abrasions _____ Bruises _____

    Were you unconscious? ❑ yes ❑ no

    Were you transported to a hospital? ❑ yes ❑ no Name of hospital _____

    Length of hospital stay (days and/or hours) _____ Name of hospital doctor _____

13. Have you had other personal injuries or accidents? ❑ yes ❑ no

    If yes, indicate when: ❑ less than 1 year ago ❑ 1 to 5 years ago ❑ more than 5 years ago

14. Do you have an attorney? ❑ yes ❑ no Attorney's name and address _____

    _____

INFORMATION ABOUT YOUR HEALTH INSURANCE

Are you covered by Medicare? ❑ yes ❑ no Medicare no.: _____ Do you receive state insurance aid? ❑ yes ❑ no

Do you have any group, union, or personal health insurance coverage? ❑ yes ❑ no

Primary insurance company _____ Policy no. _____ Group no. _____

Address _____ Phone _____ Name of agent _____

Other insurance company _____ Policy no. _____ Group no. _____

Address _____ Phone _____ Name of agent _____

I clearly understand and agree that all services rendered to 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 services rendered to me will be immediately due and payable.

_____ _____

Patient's signature **Date**