Edwards Chiropractic LLC, 2766 West College Ave, Ste 200, State College, PA 16801
P: 814-308-9397 F:814-308-9405

CONFIDENTIAL PATIENT CASE HISTORY

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Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case. Thank you.

PERSONAL INFORMATION:

Patient's Full Name:______________________________ Date:______________

Address:__________________ City:____________ State:__________ Zip: __________

What do you prefer to be called? ______________________ Number of Children: __________

Home Telephone Number: __________________ Work Telephone Number: ______________

Cellular Telephone Number: __________________ E-mail Address: ________________

Employer's Name: __________________________ Occupation: ______________

Birth Date: __________________ Age:________ Social Security Number: ______________

Marital Status: (circle one) M S W D Spouse's Name: ______________________

Whom may we thank for referring you to our office? ______________________

In Case of Emergency, Notify:____________________ At Telephone Number:____________

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INSURANCE INFORMATION

Insured Person's Name:______________________________________

Insured Social Security Number:__________________ Insured's Birthday:______________

Relationship to Patient:______________________________________

Name of Insurance Carrier:__________________ Insured's Employer:______________

Do you participate in an Employer Health Reimbursement Plan? (HRA, HSA, Flex Spending Account? **Yes No**

SECONDARY INSURANCE INFORMATION

Insured Person's Name:______________________________________

Insured Social Security Number:__________________ Insured's Birthday:______________

Relationship to Patient:______________________________________

Name of Insurance Carrier:__________________ Insured's Employer:______________

Do you participate in an Employer Health Reimbursement Plan? (HRA, HSA, Flex Spending Account? **Yes No**

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HEALTH INFORMATION

Have you had previous chiropractic care? **Yes No** Where?______________________

Major Complaint (Why are you here today?):______________________________

How long have you had this condition?______________Have you had this problem in the past?________

How often does this occur (ex: x times per day, week, month)? ______________________

Rate your pain on a scale of 1-10 (10 being the worst pain imaginable, 1 equaling no pain):__________

Other complaints:______________________________________

What activities aggravate your conditions?______________________________

Is this condition interfering with ______Work______Sleep______Daily Routine______Other (please describe)

____

How long since you've felt really good?____________ Surgical Operations and Years?______________

____

Medications you now take:______________________________________

____

Vitamins/Herbs you now take:______________________________________

____

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CONFIDENTIAL PATIENT CASE HISTORY Continued

Is your condition due to an auto accident or job related injury? **Yes No**
Date of Accident:____________

Date of your last physical exam: ________________
FEMALES: Is there any chance that you are pregnant? **Yes No**

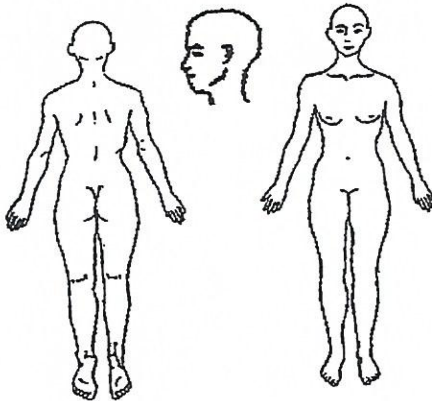
Have you been in any automobile accidents in: ____past 2 yrs ____past 5 yrs ____over 5 yrs ____never
If so, please describe the auto accident:____

____

Have you had any other personal injury accident in: ____past 2 yrs ____past 5 yrs ____over 5 yrs ____never
If so, please describe the accident: ____

____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



HAVE YOU SUFFERED FROM:

BACKACHES?	**YES**	**NO**
NECK PAIN?	**YES**	**NO**
HEADACHES?	**YES**	**NO**
SINUS TROUBLE?	**YES**	**NO**
NERVOUSNESS?	**YES**	**NO**
DIGESTIVE DISORDERS?	**YES**	**NO**
ASTHMA?	**YES**	**NO**
DIZZINESS?	**YES**	**NO**
ARTHRITIS?	**YES**	**NO**
HEART TROUBLE?	**YES**	**NO**
DIABETES?	**YES**	**NO**

AGREEMENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I authorize this Chiropractic Office to furnish all information to the insurance company regarding my condition including the history obtained, x-ray physical findings, diagnosis and prognosis. Any necessary reports and forms will be prepared by this office to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand an 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.

PATIENT SIGNATURE:____**DATE:**________________

****Please Note:** Without proper notification of cancellation of an appointment (24 hrs.), you, the patient, may automatically be billed for the office visit.