

New Patient Case History

Date: / / Patient Number:

PERSONAL DATA

Name _____ SS # _____ Birthday: / /
Address _____ Home # _____ Cell # _____
City _____ State _____ Zip _____ Work # _____
Marital Status: S M D W Partnered Spouse/Partner's name _____ Age of Children _____
Your occupation _____ Employer _____
Employer address _____ Who referred you to us? _____

YOUR HEALTH HISTORY

Have you been under Chiropractic care before? _____ When? _____ How long? _____
Chiropractor's name _____ Why did you discontinue care? _____
Reason(s) for consulting this practice: _____

Please check any of the following statements that describe(s) your current goals for your health and well being:

- I am only concerned about relief of a particular symptom.
- I am concerned about relief of a particular symptom, and preventing its return.
- I want to perform at my highest capacity.

The human body is designed to express health, to function normally. However, events and stresses may occur which can cause interferences with this natural ability. Interferences are most commonly caused by vertebral subluxations; subluxations are spinal joints which do not work properly and interfere with the transmission of nerve impulses. Since normal body function is governed by these impulses, interferences can deeply affect your wellbeing.

Any stress to which your body cannot adapt may cause subluxations. These stresses may be physical, chemical, or emotional in nature.

Hence, the practice of chiropractic is based on the location and reduction of nerve system interference caused by the vertebral subluxation.

Please tell us about any stress associated with your birth (i.e. difficult delivery, drugs during labor). Please be complete.

Please tell us about any stress associated with your childhood (i.e. falls, broken bones, contact sports, frequent or serious illness, medications). Please be complete.

Please continue on back.

Please tell us about any adult or more recent stress or trauma (i.e. work stress, auto injuries, other trauma, surgeries, illnesses, medications). Please be complete.

Please describe the physical aspects of your daily life: (Lifting, sitting, talking on the phone, typing, etc.)

On a scale of 1-10, with 10 being optimum, how would you rate your current health? _____

If your health does not rate a 10, how likely is it that you will reach a 10 in the foreseeable future? _____

What other health care are you receiving?

What are you currently doing to either maintain or improve your health? You may want to include mental/spiritual as well as physical and chemical (diet) health measures.

(Women only) Are you, or might you be pregnant? Y N Date of last menstrual period: _____

**PLEASE READ
AND SIGN**

I affirm that the information in this case history is correct to the best of my knowledge. I also understand that I am ultimately responsible for charges on my account with Knight Chiropractic regardless of my insurance arrangements.

Signature

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature

We accept payment by cash, check and credit card.

For office use only:

DOI _____ NPC _____ DX _____