ABBOTT FAMILY CHIROPRACTIC, PC

Hayes, VA

Confidential Case History

Name:_____ Date:_____
Age:_____ Occupation:_____
Sports/Activities/Hobbies:_____
_____

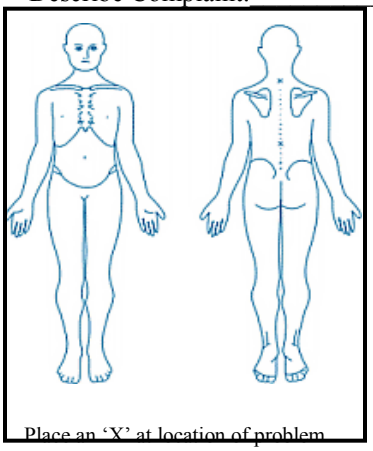
Marriage Status: ☐ Single ☐ Married ☐ Divorced # of Children:_____
How did you find out about our office?_____

Have you ever been under chiropractor care before? ☐ Yes ☐ No
If Yes, Name of Chiropractor:_____
City:_____ State:_____ Last visit date:_____
List most recent traumas (*auto accidents, falls, sport injuries, fractures, etc.*):

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____

Primary Condition

Describe Complaint:_____



Place an 'X' at location of problem

When did it start? _____

Have you had it in the past? ☐ Yes ☐ No When? _____

Does the pain ☐ come & go or is it ☐ constant?

On a scale from 1-10 with 10 being the worst, circle the level of pain
1 2 3 4 5 6 7 8 9 10

Check all boxes that apply ☐Sharp/Stabbing ☐Burning ☐Dull
☐Tingling ☐Numbness ☐Other
_____

Does the pain travel to other areas? ☐Yes ☐No / Where?_____

Have you seen other doctors for this problem? ☐Yes ☐No
If Yes, Who? _____
What makes it better?_____
What makes it worse? _____

Do any of the following aggravate your condition? ☐Walking ☐Sitting ☐Coughing ☐Sneezing
☐Driving ☐Breathing ☐Working ☐Bowel Movements ☐Sleeping ☐Other _____

Is this the result of an automobile accident? ☐ Yes ☐ No Work related injury? ☐ Yes ☐ No
If yes to either, explain: _____
What other treatment have you had for this condition? _____

Medications

Please list all medications and dosage(if known) that you are currently taking:
1)_____ 2)_____ 3)_____
4)_____ 5)_____ 6)_____

Supplements

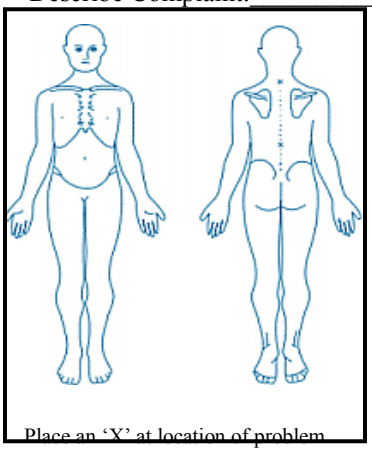
Please list all vitamin and nutritional supplements that you are currently taking:
1)_____ 2)_____ 3)_____
4)_____ 5)_____ 6)_____

Surgeries (with date)

1) _____
2) _____

Additional Condition

Describe Complaint:_____



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If yes to either, explain: _____

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Family History

Insert age and check any that apply

	Age (if living)	Heart Disease	Diabetes	Cancer	Neck Pain	Low Back Pain	Carpal Tunnel	Headaches	Smoker
Self									
Mother									
Father									
Brother									
Sister									
Other									

Primary Physician

I authorize Abbott Family Chiropractic, PC, to communicate with my primary physician about the care I receive at this office.

Primary physician:_____City:_____St:_____

Signature:_____Date:_____

Female Only

Are you currently having menstrual cycles? ☐ Yes ☐ No If Yes, first day of your last cycle? _____

Is there any chance that you are pregnant? ☐ Yes ☐ No If No, Sign here:_____

Financial Arrangement

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our customers are able to receive the care that they need in an affordable manner. If you have insurance coverage, our office will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days, will ultimately become your responsibility. The amount of your insurance coverage and the out of pocket expenses will be discussed in detail and convenient payment plans will be available.

I have read and understand the statements above and give the doctor permission to evaluate me.

Name:_____Signature:_____Date:_____