Date: _____ Case #: _____

WELCOME TO ALLENTOWN CHIROPRACTIC CENTER, P.C.

CASE HISTORY

PERSONAL

Name: _____ Date of Birth: _____ Age: ___
Address: _____ Phone #: _____
City _____ST ___ ZIP_____ Cell #: _____
SS #: _____ Work #: _____
Occupation: _____ Gender: (circle one) M or F
Employer: _____ Marital Status: _____
Preferred Language Spoken: _____ Number of Children: _____
E-mail address: _____@ _____

By providing your email address, we may add you to our email list – only for occasional announcements or communication

Preferred method of communication: (circle one) Home phone # Cell # Work # Other: _____
Race: (circle one) African American American Indian Asian Native Hawaiian White Mix (2 races) No answer
Ethnicity: (circle one) Hispanic/Latino Non-Hispanic/Non-Latino No answer
* *How did you find out about us? :* _____ *

SPOUSE INFORMATION

Name: _____ Date of Birth: _____
SS #: _____ Employer: _____

PAYMENT TYPE - PLEASE CIRCLE: SELF-PAY/CASH PERSONAL INSURANCE AUTO INS WORKERS COMP INS

INSURANCE

Insurance Carrier: _____ Policyholder: _____
Policy/ID #: _____ Group #: _____
Relation to policyholder – you are: (circle one) Self Spouse Child
Policyholder Date of Birth: _____
Additional/Secondary coverage: _____
Policy/ID#: _____ Group #: _____

PLEASE PROVIDE YOUR INSURANCE CARD(S) & DRIVERS LICENSE/PHOTO ID FOR COPYING

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____
Home #: _____ Cell #: _____ Work #: _____

HEALTH HISTORY

Present health and any complaints or problems, including why you are here: _____
_____

Duration of this condition/how long you have had symptoms? _____

Is your problem due to: __Accident __Injury __Other: _____- Reported to: _____

Diagnosis (by MD or others and approx. dates): _____

Patient Name: _____ #: _____ Date: _____

Have you been under previous Chiropractic Care? **NO** **YES** If yes, by whom, dates, and treatment areas: _____

Have you had any x-rays or MRIs? **NO** **YES** If yes, what facility, what area of the body, and approximate dates:_____
_____

What is the name of your primary care physician? _____
Phone # and/or location: _____

Any other regular specialists or doctors? **NO** **YES** If Yes, list: _____
_____

List any other health information, including any medications: _____
_____

Do you have any allergies? **NO** **YES** If yes , list allergies: _____
_____

Do you smoke or use tobacco products? **NO** **YES** If yes, type and frequency, including packs or # of cigarettes per day: _____

	TYPE OF SITUATION	***DOCTOR/HOSPITAL***	***DATES***
ILLNESSES:			
OPERATIONS:			
ACCIDENTS: (INCL. CAR OR FALLS)			
FRACTURES:			
PHYSICAL IMPAIRMENTS:			

If applicable, circle one: Do you wear glasses or contacts or none ?

FAMILY HISTORY

Please check if any of the following apply to any **family members** – parents, grandparents, children, siblings:

□ **Cancer** □ **High Blood Pressure** □ **Diabetes** □ **Heart Problems/Stroke**
□ **Rheumatoid Arthritis** □ **Liver Disease** □ **High Cholesterol** □ **Alcohol/Drug Abuse**
□ **Genetic (inherited) disorder** □ **Depression/Psychiatric Illness** □ **Other: _____**