CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Phone _____ E-mail Address _____
SS # _____ Driver Lic. # _____
Age _____ Birth Date _____ Sex _____ Status M S W D No. Children _____
Occupation _____ Employer _____ Work Ph. _____
Work Address _____ City _____ State _____ Zip _____
Best Times to Reach Me: _____ or _____. I prefer to be reached at Home Work
Spouse's Name _____ Occupation _____ Employer _____
Person Responsible for this account _____ Referred by _____

List surgical operations: _____
_____
Prescription Drug(s): _____
Non-Prescription Drug(s) / Supplements: _____
OTHER DOCTORS SEEN FOR THIS CONDITION : DC MD DDS DO
Doctor's Name _____ Diagnosis _____
X-Rays and Lab Studies: _____
Treatment Rendered: _____
Results: _____ Time under care _____
Were you off work? _____ If so, how long _____ Have you returned to the same job? If not, why _____

INSURANCE INFORMATION

Insurance Co. _____ Claim# _____ Group# _____
Address _____ Ph. _____ Agent _____
Insurance Co. _____ Claim# _____ Group# _____
Address _____ Ph. _____ Agent _____
Insurance Co. _____ Claim# _____ Group# _____
Address _____ Ph. _____ Agent _____
Are you covered by Medicare? Yes No Medicare # _____
Is your condition due to: Accident Illness Other _____

ACCIDENT INFORMATION

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No
Date _____ Time _____ Injury reported to Supervisor Yes No Name _____
Description of accident _____
_____
Were you injured? _____ How? _____
Location _____
Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____
Patient taken to _____ Hospital for _____
Confined to hospital for _____ Days _____ Hours. Name of hospital doctor _____
Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None
Describe:
_____
_____
_____
_____