

ABBOTT FAMILY CHIROPRACTIC, PC

Hampton, 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.*):

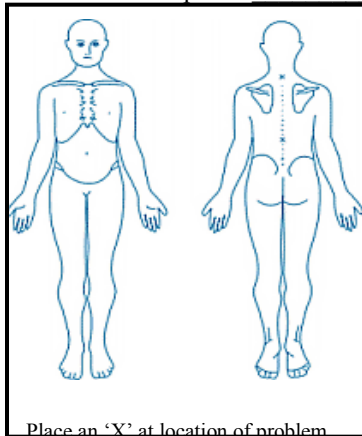
1. _____ Date: _____

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) _____

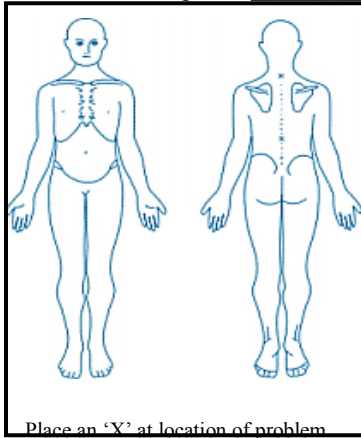
Surgeries (with date)

1) _____

2) _____

Additional Condition

Describe Complaint:



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? _____

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: _____