

CONFIDENTIAL PATIENT CASE HISTORY



Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

THANK YOU.

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D

Work Telephone _____ # Children _____ Spouse's Name _____

Occupation _____ Referred by _____ Spouse's Office Telephone _____

HEALTH INFORMATION:

Have you had previous chiropractic care? _____

What is your major complaint? _____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other _____

How long has it been since you really felt good? _____

Are you pregnant? _____

Other doctors who treated this condition. _____

List surgical operations and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers "Pep" pills Tranquilizers

Insulin Birth control pills Others _____

Age of mattress _____ Comfortable Uncomfortable

Are you wearing: Heel lifts Sole lifts Inner Soles Arch supports

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

Describe: _____

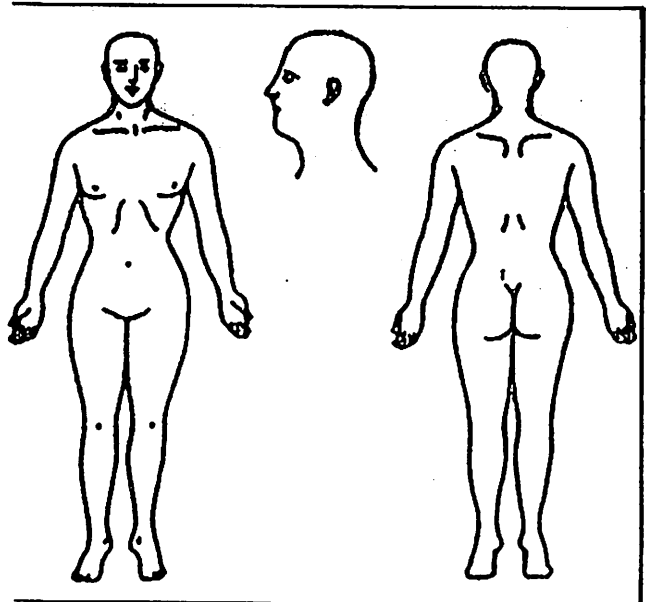
Have you had any other personal injury or accident? Past year Past 5 years Over 5 years

None

Describe: _____

Date of Last Physical Examination _____

Please mark your areas of pain on the figures below.



Have You Ever Suffered From:

- 1. Dizziness _____
- 2. Backaches _____
- 3. Heart Trouble _____
- 4. Diabetes _____
- 5. Arthritis _____
- 6. Headaches _____
- 7. Asthma _____
- 8. Neuritis _____
- 9. Digestive Disorders _____
- 10. Nervousness _____
- 11. Sinus Trouble _____
- 12. Neck Pain _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____ Yes _____ No

Do you have Health Insurance? _____ Yes _____ No If yes,

Name of Company _____ Policy # _____

Are you covered by Medicare? _____ Yes _____ No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION: (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS



Dr. Stuart K. Himmelstein, D.C.

Get "BACK" your life

REGULAR INSURANCE TODAY'S NEW PATIENT

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME NUMBER: _____ WORK NUMBER: _____

SOCIAL SECURITY: _____ DATE OF INITIAL: _____

DX: _____

INSURANCE CO.: _____

IDENTIFICATION NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ EFFECTIVE: _____

CHIRO COVERAGE: _____ DEDUCTABLE: _____

LIMIT: _____ COPAY: _____ PRIMARY: _____

REFERRAL NEEDED: YES OR NO

POLICY HOLDER: _____ RELATIONSHIP TO: _____

SPOKE TO: _____ CONFIRMED BY: _____

PHYSICAL THERAPY BENEFITS: _____

DURABLE MEDICAL EQUIPMENT: _____

MASSAGE THERAPY: _____



Dr. Stuart K. Himmelstein, D.C.
Get "BACK" your life

Records Release Authorization

To: _____

I, _____ hereby request that you release to:
(Patient's Name or Guardian)

Stuart K. Himmelstein, D.C.
2981 Grant Avenue
Philadelphia, Pa 19114
Tel: 215-632-3074

A report of diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from _____ to _____

(Date of Request)

(Patient's Signature)

(Address)

(City, State, Zip Code)