

The Sports Therapy Center L.L.C.

Confidential Patient Case History

Dear Patient,

Please complete this questionnaire. Your answers will help us determine if our treatment protocols are appropriate for you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. We have an exceptional referral network of physicians if your condition is beyond our scope of practice. Thank you.

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Age _____ Birthday _____ # of Children _____

E-mail address _____

Marital Status M S W D Occupation _____

Spouse's Name _____ Spouse's Work Phone _____

Referred By _____ Nearest Relative and Phone _____

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? (Please be specific)

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've really felt good?

Other doctors who have treated this condition?

List surgical operations and years _____

Drugs you now take: Pain Killers Muscle Relaxers Tranquilizers Insulin Birth Control

Other medication:

Age of mattress _____ Is it comfortable or 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

Please describe:

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

None Describe: _____

Date of last Physical Examination

Primary Care Physician (name, address and telephone) _____

Have you ever Suffered from :

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Backaches	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Sinus Trouble	
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Weakness	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Lack of Coordination

What are your expectations of the Doctor and treatment?

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 # _____

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 upon 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 fee for professional services rendered me will be immediately due and payable.

I will be paying today by: Cash Check Credit Card

Patient's signature _____ Date _____

Guardian or Spouse's Signature
_____ SSN _____