Bunker Hill Chiropractic Clinic

Confidential Patient Case History

*The Following Information is REQUIRED:

This information MUST be complete or we will not be able to bill your insurance and you will be responsible for all or part of the bill.

Date: ______________________ Patient Name: ____

Phone #: (______)_____-__________ D.O.B. ____/____/____ Age: __________________________

S.S.N. #: _____-_____-________ Address: ____

City: ________________________________ State: ______________________ Zip: ________________

Marital Status: ____________________________ # of Children: ________________________________

Name Of Insurance: (if applicable) ____

ID#: _________________________________ Group#: ____________________________________

Policy Holder's Name: ___________________________________ D.O.B:_____________________

Social Security #: (required for billing insurance) ______-______-_________

Employer:____

Employer's Phone#:(______)_____-__________

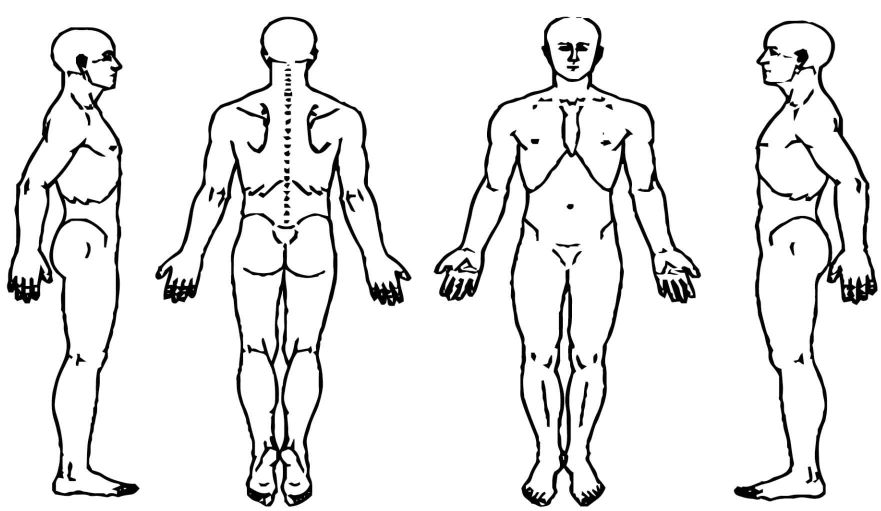
* *

Who referred you to our office? ____

Have you had chiropractic treatment before? ☐ YES ☐ NO

When? ____

Indicate where you have pain or other symptoms on this chart.



PLEASE FILL OUT BOTH SIDES OF THIS FORM

TURN OVER NOW

What is your major complaint?_____
How long? _____ Is it getting worse? _____
Have you had a similar condition before? _____
Other complaints? _____
How long? _____ Is it getting worse? _____
Similar condition before? _____
Off work? □ YES □ NO Trouble sleeping? □ YES □ NO Other? _____
Have you been in an auto accident? □ YES □ NO When? ____/____/_____
Are you wearing supports in your shoes? □ YES □ NO Age of mattress? _____

How often do you experience your symptoms?

1. Constantly (76-100% of the day)
2. Frequently (51-75% of the day)
3. Occasionally (26-50% of the day)
4. Intermittently (0-25% of the day)

What describes the nature of your symptoms?

1. Sharp
2. Dull ache
3. Numb
4. Shooting
5. Burning
6. Tingling

During the past 4 weeks:

1. Indicate the average intensity of your symptoms

none unbearable
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

2. How much has pain interfered with your normal work?
(including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

Contact information of nearest relative not living in your home:

Name: _____ Phone #: (_____)_____- _____
Relationship: _____