

Oakland Chiropractic Clinic PLC Case History

Date _____

Please complete this form to the best of your ability. If you need help our receptionist will be glad to assist you!

Full Name _____ Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Phone (Work) _____ Cell _____

E-mail _____ Sex: M F Single / Separated / Married / Widowed / Divorced

Birth _____ Social Security# _____ How did you hear about our office _____

Employed / Student / Other Employer _____ Type of work _____

Emergency Contact _____ Phone _____ Relationship _____

Family Physician _____ Would you like a report sent to your doctor? Yes No

Type of Payment you plan to use (circle): **Insurance Cash Credit Card Medicare Other**

Your Family

Spouse's Name _____ Date Of Birth _____ Social Security# _____

Name and age of children _____

Accident Injury Information

Are your present problems due to an accident-injury? _____ Date _____

Type of accident-injury (circle): **Auto On-the-Job Sports Military Household Slip/Fall Personal Other**

Insurance Information (IF YOU HAVE BEEN IN AN AUTO ACCIDENT; circle Auto and proceed to next section.)

Type of Insurance you plan to use to help pay your account (circle): **Auto Health Medicare On-the Job Other**

Insurance company _____ Phone _____

Insured's Name _____ Insured's DOB _____

Your Injury, Illness, or Condition

What is your injury, illness or condition _____

Names of other doctors seen for this condition _____

Type of previous treatment and/or surgery for this condition _____

Results of previous treatment (circle): **Good Fair Poor Other** _____

Medication you are presently taking _____

Do you suffer from any condition other than that which you are now consulting us? _____

Have you been treated for any health condition in the last year? Y _____ N _____ If YES please explain _____

Previous Chiropractic Care

Name of chiropractor _____ Condition treated _____

Results of treatment _____ Date of last visit _____

Health Problems

CIRCLE conditions you have NOW and UNDERLINE conditions you have had PREVIOUSLY:

- | | | | |
|-------------------------------|-----------------------|---------------------|---------------------|
| Low Back Pain | Fractured Bones | Spinal Taps | Fainting |
| Arm Pain | Dislocation | Scoliosis | Birth Defects |
| Headaches | Joint Replacement | Diabetes | Osteoporosis |
| Neck Pain | Metal Screws/implants | High Blood Pressure | Cancer |
| Pain Between Shoulders | Cervical Whiplash | Stroke | Tumor |
| Leg Pain | Electronic Implant | Aneurysm | Cyst |
| Cold/Tingling Fingers or Toes | Pacemaker | Convulsions | Ear Infections |
| Numbness | Ruptured Spinal Disc | Seizures | Birth Complications |
| Allergies | Slipped spinal disc | Memory Lapse | Asthma |
| Loss of Sleep | Pinched Nerve | Dizziness | Bed Wetting |
| Stomach/Digestive Problems | Spinal Surgery | Concussion | Heart Disease |
| Walking problems | Spinal Infections | Knocked Unconscious | Fever |

Are you Pregnant? Y _____ N _____ Other serious illness _____

Criteria to be accepted as a Patient

Unfortunately, we cannot accept everyone as a patient so patients are accepted on a necessity and patient commitment criteria.

1. We must feel your condition is serious enough to necessitate treatment
2. We must feel we will have very favorable results from your treatment.
3. In the event you cannot make an appointment you agree to call in advance to reschedule.

Treatment Authorization

I hereby authorize Oakland Chiropractic Clinic PLC and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that statements made in any video presentation are made by non-doctors. I authorize the use of this signature on all insurance submissions and I certify my sole purpose of entering this office is for healthcare.

Patient's signature (x) _____ Date _____

Consent To Treat a Minor

I (we) being the parents, guardian or custodian of the minor being _____, Age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature _____ Date _____

Witness _____ Date _____

If your injuries could be due to an AUTO ACCIDENT, please fill out this page.

Accident Patient History

Date of Accident _____ Time _____

Were you: Driver Passenger Front Seat Back Seat

Were you wearing a Seat Belt? Y____ N____ Shoulder Harness? Y____ N____

Description of Accident

Were you struck: From Behind In Front Right Front Right Middle Right Rear
 Left Front Left Middle Left Rear

Were you: Moving Stopped Turning Right Turning Left

Approximate speed of automobiles at time of impact _____

Did you see the accident coming? Y____ N____

Which way were you looking at the time of impact? _____

Upon impact which way was your body thrown? Forward Backward Right Left

Did you hit your head on anything? Y____ N____ What? _____

Lose consciousness? Y____ N____ How Long? _____

Amount of damage to vehicle? _____

Type of vehicle? _____

Police report filed? Y____ N____ What county? _____

Citation issued? Y____ N____ To whom? _____

When did the pain begin? _____

Since Motor vehicle accident- pain is: Less Same Worse

Transported to hospital? Y____ N____ Hospital Name: _____

X-rays taken? Y____ N____

Instructions from ER Doctor _____

Have you seen another Dr. since Motor Vehicle Accident? Y____ N____

Dr. Name _____

What treatment did you receive? _____
