

## PATIENT CASE HISTORY

DATE: \_\_\_\_\_

Name: \_\_\_\_\_  
Last Name First Name

Home  
Cell \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS \_\_\_\_\_ Marital Status S M W D

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Nearest Relative: \_\_\_\_\_ Phone \_\_\_\_\_ Referred by \_\_\_\_\_

Purpose of this appointment: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Were you hurt on the job? Y N Have you had this condition in the past? Y N

If so, when? \_\_\_\_\_ Have you ever been in an auto accident? Y N

If so, when? \_\_\_\_\_ Describe the injuries and treatment \_\_\_\_\_

**HEALTH HISTORY** Last physical exam, Date \_\_\_\_\_ Doctor \_\_\_\_\_

Other doctors seen for present condition: \_\_\_\_\_

Have you had previous chiropractic care? Y N If so, when? \_\_\_\_\_

Please list any vitamin/mineral supplements, prescription or over the counter medications you are presently taking. \_\_\_\_\_

Are you pregnant? Y N

Comments \_\_\_\_\_

### PAYMENT IS EXPECTED AT TIME OF VISIT

*We gladly accept cash or personal checks: we do not accept credit cards at this time (6/2004)*

Person Responsible for payment: \_\_\_\_\_

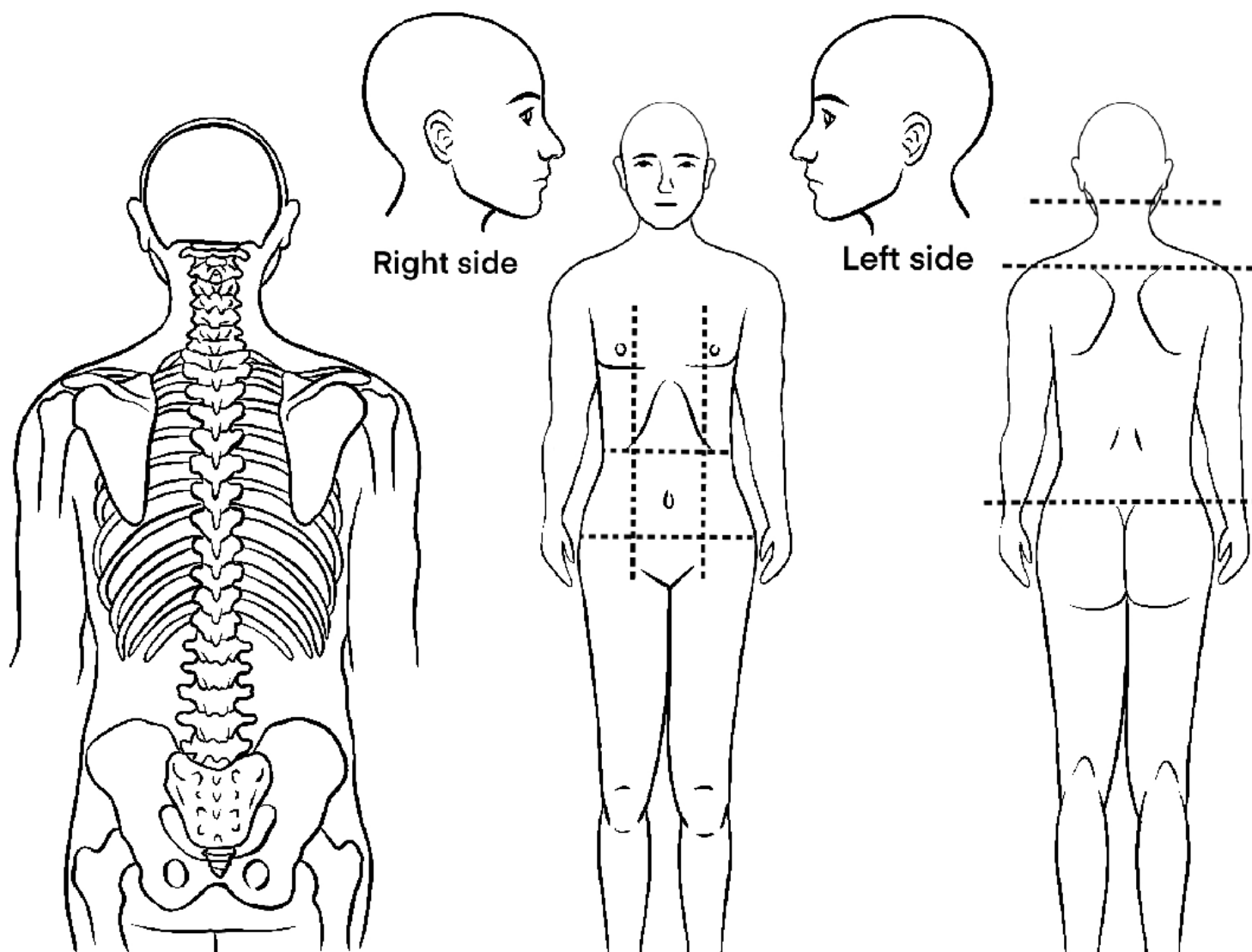
Address/phone: \_\_\_\_\_

Are you insured? Y N

What is your insurance? \_\_\_\_\_

I understand and agree that Health and Accident Insurance Policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Dean A. Johnson, D.C., will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I [Click or tap here to enter text.](#) clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I hereby authorize Dr. Dean A. Johnson, D.C., and any assistants of his choice to render care to me or to the dependent I have brought to him for care.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Notes:

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