PATIENT CASE HISTORY

DATE: _____

Home ◯

Name: _____ _____ Cell ◯ _____

Last Name First Name

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: _____

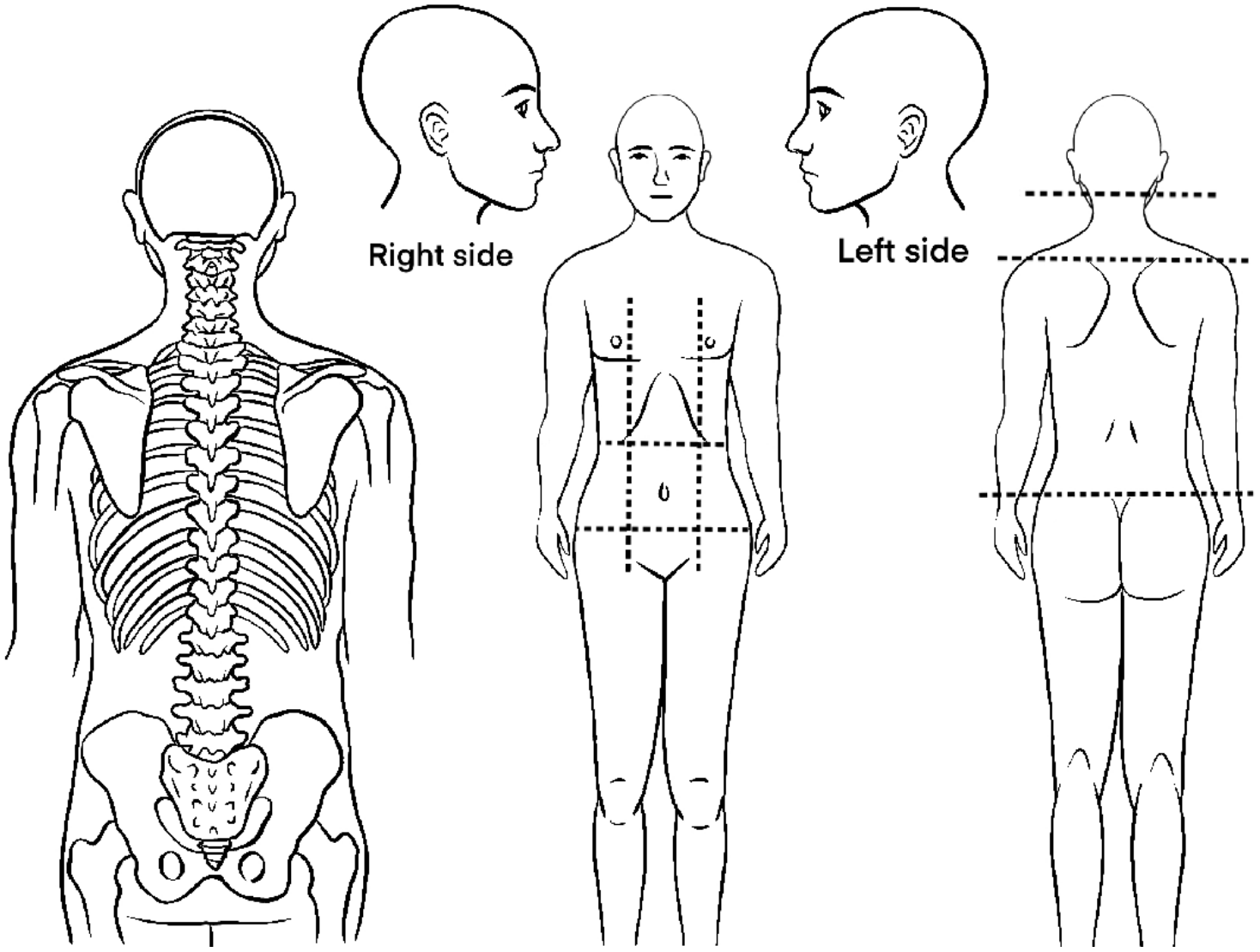
Address/phone: _____

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 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: