

NO-FAULT CASE HISTORY

Name: _____ SS #: _____

Address: _____
Street City State Zip Code

Home #: () _____ Cell #: () _____

Name of Cell Phone Carrier: _____ E-mail Address: _____

Work Phone: _____ Work Fax: _____ Supervisor: _____

Date of Birth: _____ Gender – M F Marital Status: M S D W

Employer's Name: _____

Employer's Address: _____

Emergency Contact Name/Relationship: _____ Phone #:() _____

Auto Related: Yes No Are you working now? Yes No Last Date Work: _____

Date of Injury: _____ **Police Report Filed:** Yes No

Accident Reported to YOUR Insurance Company: Yes No

Insurance Company's Name: _____

Policy #: _____ Claim #: _____

Attorney Info: _____

Describe How This Accident Occurred: _____

Where are you feeling pain? _____

Please indicate on the diagram using X where you feeling pain

Is your pain getting: Better Worse Staying Same

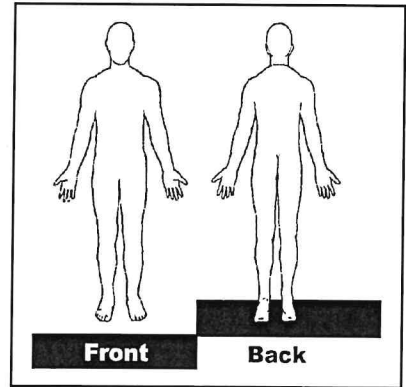
What relieves the pain? _____

Does the pain interfere with: Work Sleep Walk Sit

Have you been treated for present condition? Yes No

If yes, who treated you? _____

Have you ever had a similar condition, if yes when? _____



List Current/Past Medications: _____

List Surgical Procedures: _____

List any Medical History: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare all necessary reports and forms to assist me in making collection from the Insurance Company and that an amount authorized to be paid directly to this office will be credited to my account. 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 terminate my care, any fees for services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

X-Ray Authorization

[] I agree to have X-rays taken [] I refuse X-ray testing [] I am pregnant [] I am not pregnant

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____