SCOTT CHIROPRACTIC & WELLNESS CLINIC

Patient Case History

Date _____ Patient/Clinic I.D.# _____

Name _____ Social Security# _____

Address _____City _____State _____Zip_____

Home Phone _____ Cell Phone _____

Email Address _____

Sex ❑ M ❑ F Age _____ Date of Birth _____ ❑ Single ❑ Married ❑ Widowed

❑ Separated ❑ Divorced Occupation _____ Shift 1 2 3

Description _____ Employer _____

Work Phone _____ Ext. _____ Years Worked _____

Spouse _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone _____

Last Doctors' Name _____

Care Received _____

Are your present problems due to an injury? ❑Yes ❑ No ❑ On the Job ❑ Auto Collision ❑ Personal Injury ❑ Other

Have you made a report of your accident? ❑ Yes ❑ No ❑ To Employer ❑ Auto Carrier ❑ Other _____

Has the accident been reported? ❑ Yes ❑ No ❑ Worker's Comp ❑ Auto Carrier ❑ Other _____

Are you now or have you ever been disabled/impaired? (Service or Work?) ❑ Yes ❑ No When _____

Have you retained an attorney? ❑ Yes ❑ No Name & Address_____

CHIEF COMPLAINT / REGIONS OF PAIN

1)_____

2)_____

3)_____

4)_____

Please check the following if you are interested:

❑Vitamins/Minerals ❑ Inversion Tables

❑Losing Weight ❑CBD Products

❑Dry Needling ❑Custom Made Foot Orthotics

❑Bed Mattresses