

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 Free Basic Health Assessment
- Losing Weight Dry Needling
- Custom Made Foot Orthotics
- Contour Pillows Body Scan for 172 Biomarkers
- CBD Oil Non-toxic cleaning products