Confidential Patient Case History

Date__________ Name____ Male or Female Age_____ Birth date__________

Address______________________________City__________________Zip_________ E-mail____________________

Home#_________________ Work #_________________ Cell #_________________ Marriage status M S W D

Social Sec. #______-____-_______ No. of children________ Occupation_________________ Employer____________________

Employer's Address______________________________City_________________Zip_________ Years Employed_________

Spouses Name___________________ How did you hear about us?_________________Person responsible for acct____________

Your major complaint____________________________**Date started**________________ **Have you had this before**________

Is your major complaint getting worse? Yes No Constant Comes & goes **Interferes with:** Work Sleep Daily Routine Other

What aggravates your major complaint?______________________________ **When did you really feel good?** ____________

Other doctors seen for this condition____

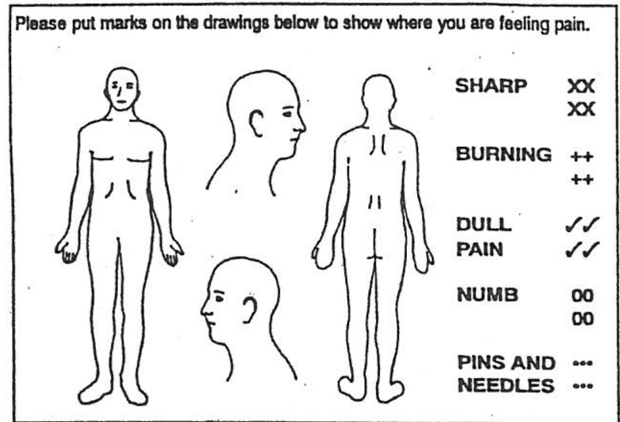
Secondary complaints____**Date started**__________________

Have you had previous chiropractic care?__________ **If yes, last date of care**________________________

Please check any of the following symptoms which you now have or have had previously:

_____ Neck Problems	_____ Sore Muscles	_____ Allergies
_____ Shoulder Problems	_____ Walking Problems	_____ Hay Fever
_____ Arm Problems	_____ Broken Bones	_____ Asthma
_____ Numbness-Arms	_____ Muscle Cramps	_____ Eczema
_____ Pain Between Shoulders	_____ Weak Muscles	_____ Shingles
_____ Low Back Problems	_____ Headaches	_____ Nausea
_____ Leg Problems	_____ Dizziness	_____ Poor Digestion
_____ Numbness-Legs	_____ Fainting	_____ Ulcers
_____ Loss of Feeling	_____ Forgetfulness	_____ Diarrhea
_____ Stiff Joints	_____ Depression	_____ Constipation
_____ Painful Joints	_____ Vision Problems	_____ Kidney Infection
_____ Restricts Daily Activities	_____ Ear Pain/Noises	_____ Menstrual Cramps
_____ Restricts Regular Exercises	_____ Ear Infections	_____ Diabetes
	_____ Hearing Loss	_____ Blood Pressure High/Low
_____ Hearing Loss	_____ Tiredness/Fatigue	

Please put marks on the drawings below to show where you are feeling pain.



List surgical operations and years:____

WOMEN: Are you pregnant ☐ YES ☐ NO Date of last period ____________ Hysterectomy ☐ YES ☐ NO Menopause ☐ YES ☐ NO

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others____

Age of mattress ____________________ ☐ Comfortable ☐ Uncomfortable Do you use a bed board: ☐ Yes ☐ No

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Arch supports

Have you been in auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When?_______________________________

Have others in your family had such disorders? ☐ Yes ☐ No When?_______________________________

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

DATE OF LAST:	Less than 6 months	6-18 months	Over 1 year
Spinal Examination	☐	☐	☐
Physical Examination	☐	☐	☐
Blood Test	☐	☐	☐
Chest X-ray	☐	☐	☐
Spinal X-ray	☐	☐	☐
Dental X-ray	☐	☐	☐
Urine Test	☐	☐	☐

HAVE YOU EVER:	YES	NO
Been knocked unconscious?	☐	☐
Used a cane, crutch, or other support?	☐	☐
Been treated for a spine or nerve disorder?	☐	☐
Had a fractured bone?	☐	☐
Been hospitalized for other than surgery?	☐	☐

DO YOU:	YES	NO
Now take vitamins or minerals?	☐	☐
Think you may need vitamins or minerals?	☐	☐
Have an allergy to any drug?	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home) NAME________________________ PHONE __________

ADDRESS____

Please check the type of care desired: ☐ **Temporary Relief** ☐ **Lasting correction**
☐ **I want the best recommended plan for me**

INSURANCE INFORMATION:

Name of insurance company:______________________________

Name of policy holder:__________________________________ Their date of birth:____/____/____

I UNDERSTAND ALL PAYMENTS ARE DUE THE DATE OF SERVICE.
BELOW I HAVE CHECKED THE METHOD OF PAYMENT I PLAN TO USE TO TAKE CARE OF TODAY'S CHARGES:
CHECK ___ CASH ___ MASTER CARD ___ VISA ___ DISCOVER ___

PLEASE READ AND THEN SIGN ALL THE SPOTS WITH AN X

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 suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature:X______________________________________ **Date:** __________

If Patient is a minor, a parent or legal guardian authorizing care should PRINT their name and then sign and date below.

Printed Name____

Signature____ Date____________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete. This is for the full extent of my treatment by Dr. Ruf and until such time that my medical expenses incurred have been paid in full.

Patient's Signature: X______________________________Date ___________ Witness__________________

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the Insurance Company/Insurance Administrator to pay by check made out and mailed directly to: Caring Chiropractic Center, P.A. 10811 Xavis St NW, Coon Rapids, MN 55433 for the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner any balance of said professional charges, I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature: X_____________________________Date _______________ Witness_________________