

SCOTT CHIROPRACTIC 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 _____ List Medications _____

_____ 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) _____

HABITS

Smoking Packs/Day _____

Alcohol Cups/Day _____

Coffee Cups/Day _____

Soda Pop Cups/Day _____ Type _____

EXERCISE

None

Moderate

Daily