CONFIDENTIAL CASE HISTORY

Chiropractic For Health
6-16 E. Blackwell St. * Dover, NJ 07801
(973)328-2588

Date:_____ **Reffered By:**_____

Name_____ **Age**_____ **Height**_____ **Weight**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Social Security #_____ **Birthdate**_____

Occupation_____ **Phone: Home**_____

Employer_____ **Work**_____

Address_____ **Cell**_____

Marital Status S M W D **Spouse Name**_____
# of Children_____

Describe *IN DETAIL* the reason for this appointment: _____

Is this condition due to: ☐**Personal Injury** ☐**Auto Accident** ☐**Work Injury** ☐**Other**_____

When did this start?_____

Have you ever had this condition before? ☐**Yes** ☐**No If yes,explain**_____

Does anyone in your famiy have this condition? ☐**Yes** ☐**No** **Is your this condition:** ☐ **getting worse** ☐**constant** ☐**omes& goes**

Does this condition interfere with: ☐**Work** ☐**Sleep** ☐**Daily Activities** ☐**Other**_____

What activities aggravate this condition? _____

What activities alleviate this condition? _____

Have you done anything to treat this condition yourself? ☐**Yes** ☐**No If yes, explain:**_____

Have you seen any other doctors for this condition? ☐**Yes** ☐**No If yes, give names & diagnosis by each:**_____

Please check all conditions that you presently have or have had in the past:

☐**Allergy**	☐**Digestive Disorder**	☐**Rheumatic Fever**	☐**Spinal Curvature**
☐**Dizziness**	☐**Nervousness**	☐**Cancer**	☐**Numbness in arms, hands, legs, feet**
☐**Backaches**	☐**Sinus Trouble**	☐**Sciatica**	
☐**Heart Trouble**	☐**Anemia**	☐**Colds**	☐**Stroke**
☐**Diabetes**	☐ **Headaches**	☐**Hayfever**	☐**Excess Menstral Flow**
☐**Tuberculosis**	☐**Asthma**	☐**High Blood Pressure**	☐**Irregular Menstral Cycle**
☐**Arthritis**	☐**Bruise Easily**	☐**Low Blood Pressure**	☐**Alcoholism**
		☐**AIDS or HIV Virus**	☐**Polio**

Past Medical History

In order for the doctor to make an accurate assessment of your condition, the following information is required, regardless of weather or not it is related to your present condition.

Have you been treated by a physican for any condition in the past year? ☐Yes ☐No If yes, describe:_____

Have you ever been hospitalized? ☐Yes ☐No If yes,list reason and date(XX/XX):_____

Have you ever fractured any bones? ☐Yes ☐No If yes, describe and give date:_____

Have you ever been involved in any auto accident? ☐Yes ☐No If yes, describe and give date:_____

Have you ever had any other serious injuries? ☐Yes ☐No If yes, describe and give date:_____

Please list any prescription or non-prescription medications and/or vitamins that you currently take:_____

Have you ever been under chiropractic care ? ☐Yes ☐No Doctor's Name_____

Date of last adjustment:_____ **City & State**_____

Results from treatment: ☐ Good ☐Fair ☐Poor

I do hereby certify that all of my statements on this application for chiropractic care are true, accurate and complete. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I clearly understand and aggree that all services rendered me are charged direcctly to me and that I am personally responsible for payment.

Signature_____ Date_____

FOR WOMEN ONLY By my signature below, I do hereby state that, to the best of my knowledge, I am neither suspected nor confirmed pregnant at this time.

Signature_____ Date_____

CONSENT TO TREAT A MINOR CHILD I do hereby give my permission to Dr. Grant and any one the doctor directs to

treat _____.

Minor Child's Name

Signature of parent or legal guardian_____ Date_____