PARKER
health solutions

Case History

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Cell: _____

Email: _____

Age: _____ Date of Birth:_____ Sex: **Male** OR **Female**

Who referred you to us?

_____

Have you had Chiropractic care in the past?

- **YES** _____
  - What was your doctor's name? _____
  - When was your most recent treatment? _____
- **NO** _____

Chief Complaint: _____

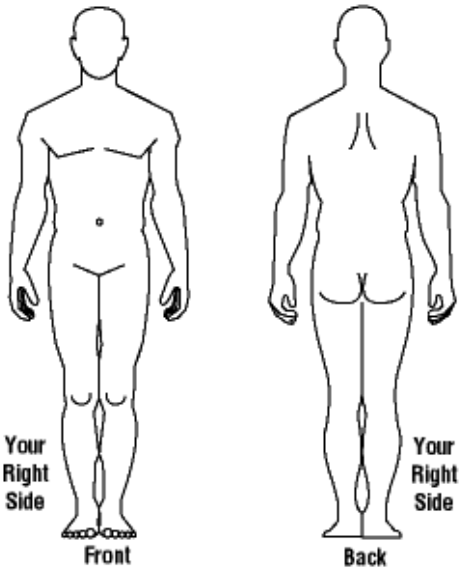
_____

How long have you had this issue? _____

Please mark the area where your pain occurs on the drawings using the codes listed below:

N – Numbness **S – Soreness** **A – Ache**

T – Tingling **P – Pain** **ST – Stiffness**



Habits

Smoking: **YES** or **NO** Packs/Day: _____

Drinking: **YES** or **NO** Alcohol: _____

Coffee: **YES** or **NO** Cups/Day: _____

Exercise

___ None

___ Moderate

___ Daily

Type: _____

Operations and Procedures

Please list any operations or surgeries that you have had:

_____

_____

List any accidents or falls and dates:

Car: _____ Recreation Vehicle: _____ Sports: _____

Other:

_____

Are you presently taking any medication – prescription or over the counter? **YES** or **NO**

Please list:

_____

_____

Are you presently taking any nutritional supplements? **YES** or **NO**

Please list:

_____

_____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Officer will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's signature: x _____ *Date:* _____

Parent's/Guardian's signature: x _____ *Date:* _____