Bartz Chiropractic

1316 SW 4th Terrace, Suite #102

Cape Coral, FL 33991

Confidential Patient Case History

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily we will not accept your case. ***Thank you.***

Date_____________________________

PLEASE PRINT CLEARLY

Name____
First Middle Last

Address____

City_______________________________________ **State**______ **Zip**__________

Soc Sec #_____________________________ **Home Phone**__________________

Cell Phone___________________ **Marital Status:** M S W D

Birthdate ___________ **Age**______ **Gender:** M F **# of Children** ________

Primary Care Physician______________________________

Employer____

How did you hear about us? __________________________

Spouse's Name_______________________________________

Spouse's Employer____________________________________

Spouse's Work Phone_________________________________

Health Information

What is your major complaint?	

How long have you had this condition?		**Have you had this or similar conditions in the past?**	**Yes No**

Have you had previous chiropractic care?	**Yes No**	**Is condition getting progressively worse?**	**Yes No Constant Comes and goes**

Other doctors who treated this condition	**Name**	**Address**

What activities aggravate your condition?	

Is this condition interfering with your:	**Work Sleep Daily Routine Other**

List surgical operations and year	**Year**	**Operation**

Prescriptions you now take	**Dosage**	**Prescription**	**Reason**

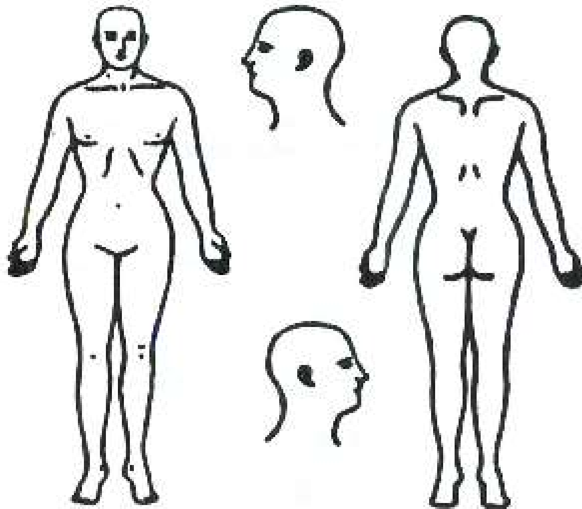
Do you smoke? ❑ **Yes** ❑ **No** **If yes, amout per week?** ______________________________

Do you drink? ❑ **Yes** ❑ **No** **If yes, amout per week?** ______________________________

Have you been in an auto accident?	**When**	**Describe**
	❑ **None**	
	❑ **Past year**	
	❑ **Past 5 years**	
	❑ **Over 5 years**	

Have you had any other personal injury or accident?	**When**	**Describe**
	❑ **None**	
	❑ **Past year**	
	❑ **Past 5 years**	
	❑ **Over 5 years**	

Please mark your areas of pain on the figures below.



Date of last physical exam___________________________

Height_________________ Weight___________________

Have you ever suffered from:

- ❑ Dizziness
- ❑ Backaches
- ❑ Heart trouble
- ❑ Diabetes
- ❑ Arthritis
- ❑ Headaches
- ❑ Asthma
- ❑ Neuritis
- ❑ Digestive disorders
- ❑ Nervousness
- ❑ Sinus trouble
- ❑ Neck pain
- ❑ Allergy/adverse reaction
- ❑ Other ____________________________

Insurance Information

Is your condition due to an auto accident or job-related injury?	Yes No	
Do you have health insurance? No Yes	Policy Number	Name of Company
Name and Address of Employer of Cardholder		
Date of Birth of Cardholder	Name of Cardholder	Relationship to Cardholder
Are you covered by Medicare? No Yes	If yes, Health Insurance Number	

I understand and agree that health and accident polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that Bartz Chiropractic, LLC will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Bartz Chiropractic, LLC 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 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____ Date__________________

Guardian or Spouse's Signature____ Date__________________

Doctor's Signature____ Date__________________

Family Health Information

(Many health problems are the result of hereditary spinal weaknesses;
thus information about your family members will give us a better picture of your total health picture.)

Name	Relation	Past and Present Health Problems