

Bartz Chiropractic
 814 Pine Island Road, Suite #306
 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 _____

Primary Care Physician _____

Address _____
First Middle Last

Employer _____

City _____ State _____ Zip _____

How did you hear about us? _____

Soc Sec # _____ Home Phone _____

Spouse's Name _____

Cell Phone _____ Marital Status: M S W D

Spouse's Employer _____

Birthdate _____ Age _____ Gender: M F # of Children _____

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

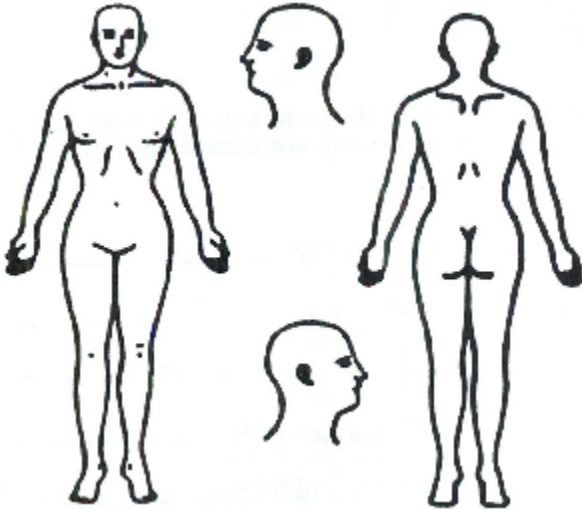
Do you smoke? Yes No If yes, amount per week? _____

Do you drink? Yes No If yes, amount per week? _____

Have you been in an auto accident?	When	Describe
	<input type="checkbox"/> None	
	<input type="checkbox"/> Past year	
	<input type="checkbox"/> Past 5 years	
	<input type="checkbox"/> Over 5 years	

Have you had any other personal injury or accident?	When	Describe
	<input type="checkbox"/> None	
	<input type="checkbox"/> Past year	
	<input type="checkbox"/> Past 5 years	
	<input type="checkbox"/> 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?	Policy Number	Name of Company	
No	Yes		
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 policies 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