WELLESLEY CHIROPRACTIC OFFICE

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Case History

PLEASE PRINT CLEARLY

Today's Date (mm/dd/yyyy)				
Patient First Name	Patient Middle Name	Patient Last Name		
Name by which you like to be called	Email Address			
Street Address			Apt/Suite	
City	State	Zip/Postal Code	Country	
Mobile Phone ( )	Home Phone ( )	Work Phone ( )		
Emergency Contact Person	Contact's relationship to you	Emergency Contact Phone ( )		
Birth Date (mm/dd/yyyy)	Age	Sex	Social Security Number _____ - ____ - _____	Marital Status S M D W DP
Occupation	Business/Employer Name			
Spouse/Partner's Name	Your children's Ages			
Who referred you here?	Relationship to you			

The purpose of Chiropractic care is to remove vertebral subluxations to restore normal function to the nervous system and allow your body to express its optimum potential

What is your reason for coming to our office?
Have you had any previous treatment? (describe)
Outcome of treatment

471 Washington Street • Wellesley • Massachusetts • 02482-5935
Telephone (781) 237-6673 Fax (781) 996-4347

Have you seen a chiropractor before? **YES** **NO** Who?	When?
How long were you under care?	Reason for stopping care
Have you ever been hospitalized? **YES** **NO** If yes, when and why?	
Have you ever had surgery? **YES** **NO** If yes, when and why?	
Do you take any medications (prescription or over-the-counter)? **YES** **NO** If yes, please list:	
Please describe any falls, accidents or injuries you have had	
Please list any orthopedic device (orthotics, TMJ appliance, braces, heel lifts, crutches, etc.) you now use or have ever used	
Are you pregnant? **YES** **NO** **MAYBE**	Please add anything else you feel is pertinent to your health

PLEASE READ AND SIGN THE STATEMENTS BELOW:

PAYMENT AND INSURANCE INFORMATION

If you are here because you have been involved in an accident (automobile, personal or work-related), please notify us immediately and fill out an additional accident information form.

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE

I, _____ am responsible for payment and I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I clearly understand and agree that all services rendered to me by Wellesley Chiropractic Office 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 to me will be immediately due and payable.

Signature _____ Date _____

Relationship to patient (CIRCLE ONE): SELF SPOUSE PARENT GUARDIAN