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.

Name_____ Social Security #_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Age_____ Birthdate_____ Marital Status: M S W D

Home Phone_____ # Children_____ Spouse's Name_____

Occupation_____ Referred by_____

HEALTH INFORMATION: Have you had previous chiropractic care? _____

What is your major complaint?_____

Other complaints: _____

How long have you had this condition?_____ Have you had this or similar conditions in the past?_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other_____

How long has it been since you really felt good?_____

Are you pregnant? _____

Other doctors who treated this condition. _____

List surgical operations and years:_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers

☐ Insulin ☐ Birth control pills ☐ Others_____

Age of mattress_____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

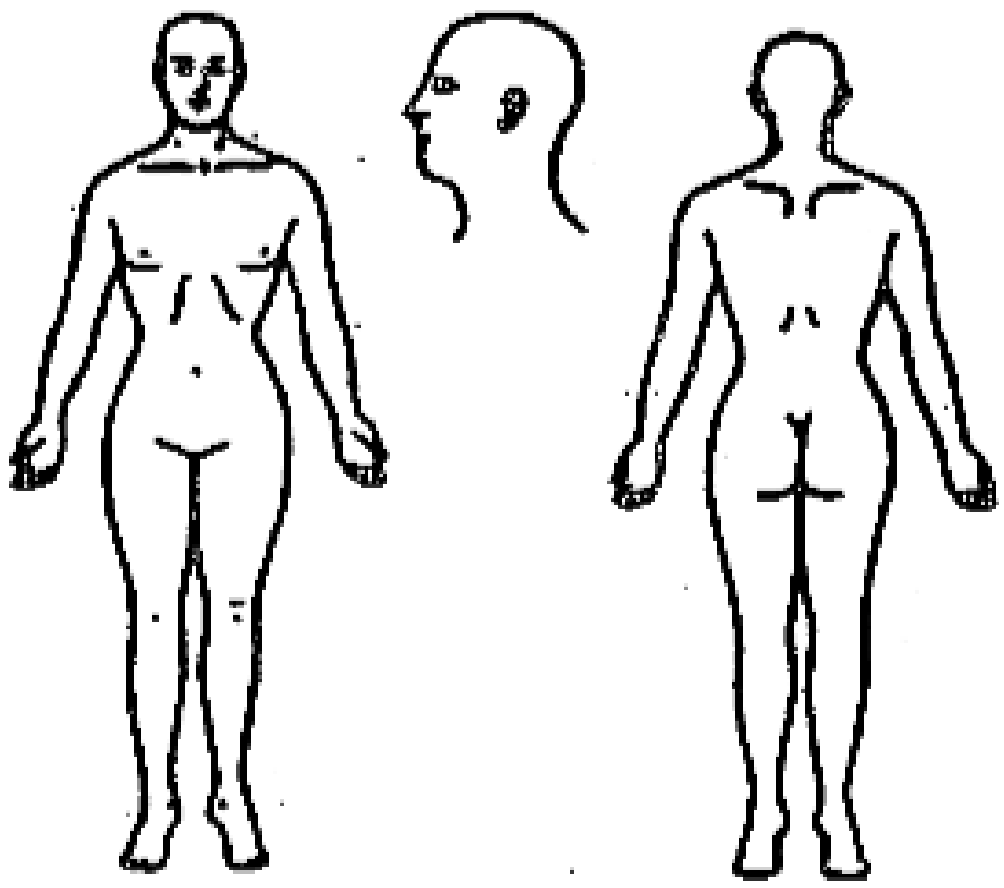
Describe:_____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years

☐ None

Describe:_____

Please mark your areas of pain on the figures below.



Have you Ever Suffered From:

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____ Yes _____ No

Do you have Health Insurance? _____ Yes _____ No If yes,

Name of Company _____ Policy # _____

Are you covered by Medicare? _____ Yes _____ No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account upon 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.

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

☐ MasterCard ☐ Visa ☐ American Express

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature: _____ S.S. # _____

Doctor's Signature: _____

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

Delaware Valley
Chiropractic & Rehabilitation
MEDICAL | CHIROPRACTIC | REHABILITATION
ORTHOPEDIC | PAIN MANAGEMENT

Call Now!
Speak Directly to a Doctor
610-376-1881
231 N. 5th Street, Reading, PA 19601

REGULAR INSURANCE
TODAY'S NEW PATIENT

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME NUMBER: _____ WORK NUMBER: _____

SOCIAL SECURITY: _____ DATE OF INITIAL: _____

DX: _____

INSURANCE CO.: _____

IDENFICATION NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ EFFICTIVE: _____

CHIRO COVERAGE: _____ DEDUCTABLE: _____

LIMIT: _____ COPAY: _____ PRIMARY: _____

REFERRAL NEEDED: YES OR NO

POLICY HOLDER: _____ RELATIONSHIP TO: _____

SPOKE TO: _____ CONFIRMED BY: _____

PHYSICAL THERAPY BENEFITS: _____

DURABLE MEDICAL EQUIPMENT: _____

MASSAGE THERAPY: _____

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Records Release Authorization

To: _____

_____

I, _____ hereby request that you release to:
(Patient's Name or Guardian)

Stuart K. Himmelstein, D.C.
2981 Grant Avenue
Philadelphia, Pa 19114
Tel: 215-632-3074

A report of diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from_____ to_____

_____
(Date of Request)

_____
(Patient's Signature)

_____
(Address)

_____
(City, State, Zip Code)