

CASE HISTORY

Moellendorf Chiropractic Office, Ltd., 1140 Egg Harbor Rd., Sturgeon Bay, WI 54235-1234, (920) 743-2126

Date _____ Case Number _____
Name _____ Phone (Home) _____ e-mail _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____ Sex M F Marital Status S M D W Spouse's Name _____ No. of Children _____
Occupation _____ Employer _____ Phone (Work) _____
Spouse's Occupation _____ Spouse's Employer _____ Spouse's Phone (Work) _____
Referred By _____ Past Chiropractic Care? Yes No When _____
Previous Chiropractor's Name _____ Results _____

Chief Complaint _____
Insurance Company _____ S.S. No. _____ Driver's License No. _____
Spouse's Insurance Co. _____ Spouse's S.S. No. _____ Spouse's Driver's Lic. No. _____
Are your present injuries due to on-the-job injury? Yes No Spinal Exam _____
Have you made a report of your accident to your employer? Yes No Disc Exam _____
Do you plan on turning it in on worker's compensation? Yes No Lab Exam _____
Are you now or have you ever been disabled (service or work)? Yes No Last Physical _____

Please enter: 1 (Never), 2 (Previously), or 3 (Presently) in front of all of the following signs and symptoms. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

____ Headache
____ Fever
____ Chills
____ Night Sweats
____ Fainting
____ Dizziness
____ Convulsions
____ Loss of Sleep
____ Fatigue
____ Nervousness
____ Loss of Weight
____ Numbness or Pain in Arms/Legs/Hands
____ Allergy (What)
____ Wheezing
____ Neuralgia

GASTRO-INTESTINAL

____ Poor Appetite
____ Poor Digestion
____ Excessive Hunger
____ Belching or Gas
____ Nausea
____ Vomiting
____ Vomiting Blood
____ Pain Over Stomach
____ Constipation
____ Diarrhea
____ Colon Trouble
____ Hemorrhoids (Piles)
____ Liver Trouble
____ Jaundice
____ Gall Bladder Trouble

EYE, EAR, NOSE, THROAT

____ Poor Vision
____ Crossed Eyes
____ Pain in Eyes
____ Deafness
____ Earache
____ Ear Noises
____ Ear Discharges
____ Nasal Obstruction
____ Nose Bleeds
____ Sore Throat
____ Hoarseness
____ Asthma
____ Frequent Colds
____ Enlarged Thyroid
____ Tonsillitis
____ Sinus Trouble

RESPIRATORY

____ Chronic Cough
____ Spitting Blood
____ Spitting Phlegm
____ Chest Pain
____ Difficulty Breathing

GENITO-URINARY

____ Frequent Urination
____ Painful Urination
____ Blood in Urine
____ Kidney Infection
____ Bed Wetting
____ Inability to Control Urine
____ Prostate Trouble

MUSCLE & JOINTS

____ Weakness
____ Twitching
____ Stiff Neck
____ Backache
____ Swollen Joints
____ Tremors
____ Foot Trouble
____ Painful Tail Bone
____ Pain Between Shoulders
____ Hernia
____ Spinal Curvature

CARDIO-VASCULAR

____ Rapid Heart
____ Slow Heart
____ High Blood Pressure
____ Low Blood Pressure
____ Pain Over Heart
____ Previous Heart Trouble
____ Swelling of Ankles
____ Poor Circulation
____ Varicose Veins
____ Strokes

SKIN OR ALLERGIES

____ Skin Eruptions
____ Itching
____ Bruising Easily
____ Dryness
____ Boils
____ Sensitive Skin
____ Hives or Allergy
____ Hay Fever
____ Eczema
____ Medicines

FOR WOMEN ONLY

____ Painful Periods
____ Excessive Flow
____ Irregular Cycles
____ Hot Flashes
____ Cramps or Backache
____ Miscarriage
____ Vaginal Discharge
____ Pregnant at this time
____ Last Pap
By Who _____
Other _____

HABITS

____ Smoking _____ pks/day
____ Drinking _____ Alcohol
____ Coffee _____ cups/day

EXERCISE

____ None
____ Moderate
____ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sisters No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

____ Appendicitis	____ Anemia	____ Heart Disease	____ Arthritis
____ Pneumonia	____ Measles	____ Goiter	____ Epilepsy
____ Rheumatic Fever	____ Mumps	____ Influenza	____ Mental Disorder
____ Polio	____ Chicken Pox	____ Pleurisy	____ Lumbago
____ Tuberculosis	____ Diabetes	____ Alcoholism	____ Eczema
____ Whooping Cough	____ Cancer	____ Venereal Disease	

OPERATIONS & PROCEDURES

Date _____ Vaccinations Date _____ Tubes in Ears Date _____ Sinus
 Date _____ Tonsillectomy Date _____ Appendectomy Date _____ Hernia
 Date _____ Gall Bladder Date _____ Female Organs Date _____ Thyroid
 Date _____ Back Operations Date _____ Rectal Surgery Date _____ Stomach
 Other _____ (list type and date)

LIST ANY ACCIDENTS OR FALLS: Car _____
 Motorcycle _____ Other _____
 Sports _____ School _____

BROKEN BONES OR DISLOCATIONS: (Fractures) _____
 Ever on Crutches? Yes _____ No _____ Why? _____
 Have you ever had any spinal taps or spinal injections? Yes _____ No _____
 Were you ever knocked unconscious? Yes _____ No _____
 Have you ever had a lapse of memory? _____ Have you ever had x-rays taken? _____
 If so, when? _____ By whom? _____
 For what ailments were these pictures made? _____
 Do you suffer from any condition other than that for which you are now consulting us? _____
 Are you presently taking any medication—Prescription or Patent? _____
 If so, what drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that Moellendorf Chiropractic will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Moellendorf Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

I hereby authorize Dr. Moellendorf to treat my condition as he deems appropriate through the use of Chiropractic Health Care. It is understood and agreed that the amount paid to Moellendorf Chiropractic for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. Dr. Moellendorf will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature _____ Date _____
 Guardian's or Spouse's
 Signature Authorizing Care _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment below.

DATE _____ SIGNATURE _____

B. I authorize payment of any medical benefits from _____ to be paid directly to Moellendorf Chiropractic Office, Ltd. for any service rendered to me.

DATE _____ SIGNATURE _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name or as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due, I personally owe to you.

DATE _____ SIGNATURE _____