

CONFIDENTIAL PATIENT HISTORY

Date _____

(PLEASE PRINT NEATLY)

PATIENT'S NAME _____ SOC SEC # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL STATUS: M S D W # CHILDREN _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ EMAIL _____

SPOUSE'S NAME _____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ WORK PHONE (____) _____

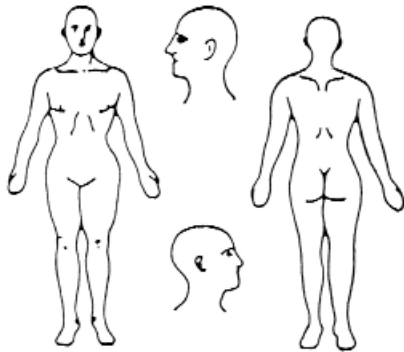
REFERRED TO THIS OFFICE BY _____

PURPOSE OF THIS APPOINTMENT _____

WHO HAVE YOU SEEN FOR THIS CONDITION? DC PT MD LMt LAc Other _____

WHAT MEDS ARE YOU TAKING? _____

PLEASE MARK YOUR AREAS OF PAIN BELOW



List conditions that you are most interested in getting corrected. List in order of importance,

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

What functions are you unable to perform, or induce pain upon performance? (example: sit, bend, walk, sleep, etc.)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Female: Are you pregnant? **Y N**

Any surgical operations? _____

Have you (or do you) suffer from (CIRCLE):

- | | | |
|-----------|---------------------|-------------|
| Dizziness | High blood pressure | Neuritis |
| Backaches | Diabetes | Nervousness |
| Headaches | Digestive disorders | Arthritis |
| Allergies | Heart trouble | Asthma |
| Cancer | Sinus trouble | Neck pain |

Have you ever had Chiropractic care? **Y N**
Doctor's name _____

Have you been treated for any health condition by an MD in the last year? **Y N**

If yes, please describe _____

Date of last physical exam. _____

By whom _____

INSURANCE INFORMATION

Name of Primary Insurance Carrier _____ Policy _____
Claims Address _____

Name of Secondary Insurance Carrier _____ Policy _____
Claims Address _____

OFFICE RULES

Appointments: Our office is very timely with regards to scheduling and it is important to us and patients scheduled after you that you be on time for your appointment. If you cannot make your appointment, please give us as much advance notice as possible. Barring emergencies, missed appointments will be charged a fee.

Fees: Unless arrangements are made in advance, visit fees are payable at the time of the visit.

Insurance: With the exception of Oxford, this office does not participate in any insurance plans.

If your case is **ACCIDENT RELATED**, check one item: Work _____ Auto _____ PI _____
Date of Injury _____ Location _____
What happened _____

To whom did you report the injury _____
Hospitalized (where) ? _____ x-rays (when) ? _____
Are you able to work? _____ Describe your work _____
What other treatments have you had? _____

PAYMENT ACKNOWLEDGEMENT

I understand and agree that my medical insurance policy is an arrangement between the carrier and myself. I understand that Dr. Schram's office will prepare any forms and reports necessary to assist me in my making collection for the insurance carrier and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment that any fees for professional services rendered to me or my dependents will be immediately due and payable.

Patient's signature _____ Date _____

Insured's signature _____ Date _____

Guardian, parent or spouse's signature _____ Date _____