

# 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 \_\_\_\_\_