

Mason Family Chiropractic & Wellness Case History and Patient Information

Date _____ Referred By _____

Patient Name _____ SS# _____

Age _____ Date of Birth _____ Marital Status: M S W D # of Children _____

Address _____

City _____ State _____ Zip _____

Home Phone: _____ Cell _____ Work _____

E-Mail Address _____ Employer _____

Occupation _____ Hobbies _____

Spouse Name _____ DOB _____ SS# _____

Work Phone _____ EXT: _____ Cell Phone _____

Emergency Contact/Relationship _____

Emergency Phone Number 1). _____ **2).** _____

Family Doctor _____ Phone _____

Please mark the appropriate insurance coverage to be billed:

Major Medical _____ Medicare _____ Auto Med Pay _____ Self Pay _____

Primary Insurance Carrier: _____

Primary Card Holder (as written on card): _____

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Carrier: _____

Secondary Card Holder (as written on card): _____

Date of Birth: _____ Social Security Number: _____

Is this appointment a result of an Auto Accident? Yes or No

Date of accident _____

Name of **your** Automobile Insurance Company: _____

Claim # _____

Agents Name _____ Phone # _____

Purpose for this appointment _____

Rate your symptoms on a scale with 10 being the worst: currently ___ /10 previously ___ /10

Date symptoms first appeared? _____ How did it occur? _____

Have you ever had the same or similar condition? Yes or No (if yes please describe):

Has it become worse recently? Yes No Same Better No change
If yes when and how? _____

How frequent is the condition: Constant Daily Intermittent Night only

How long does it last? All Day Few Hours Minutes

Is the pain Sharp Dull Numbness Tingling Aching Burning Stabbing
Other (explain) _____

Is there anything you can do to relieve the problem? Yes No (if yes please describe)

What have you tried to do to relieve the problem _____

What makes the problem worse? Standing Sitting Lying down Bending Lifting Twisting
Other _____

Have you had any broken bones? Yes No (if yes, please list and give year)

List all auto accidents or falls (please include year)

Women Only, Are you pregnant? Yes No Uncertain

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, please describe _____

Please list any medications/drugs or supplements you are currently taking: _____

Date of last physical examination _____

Any history of Cancer: Type _____ Date: _____ Family Member _____

List any surgeries you have had (include the year)

List any serious illnesses (include the year)

Do you experience headaches or migraines; (women near cycle) Yes No

