CONFIDENTIAL PATIENT CASE HISTORY

NAME:_____**GUARDIANS NAME (if minor):**_____

ADDRESS: _____**CITY:** _____**ST:** _____**ZIP:** _____

DATE OF BIRTH: _____**AGE:** _____ **MARITAL STATUS: M S D W**

CELL PHONE: _____ **HOME PHONE:** _____**WORK PHONE:** _____

EMAIL :_____ **REFERRED TO OFFICE BY:**_____

OCCUPATION: _____ **EMPLOYER:** _____

PRIMARY PHYSICIAN: _____ **IS THIS A RESULT OF A WORK OR AUTO INJURY: YES NO**

_____

WHAT IS YOUR MAJOR COMPLAINT: _____

WHEN DID IT BEGIN: _____**HOW DID IT OCCUR:** _____

PLEASE CIRCLE ONE RESPONSE PER QUESTION

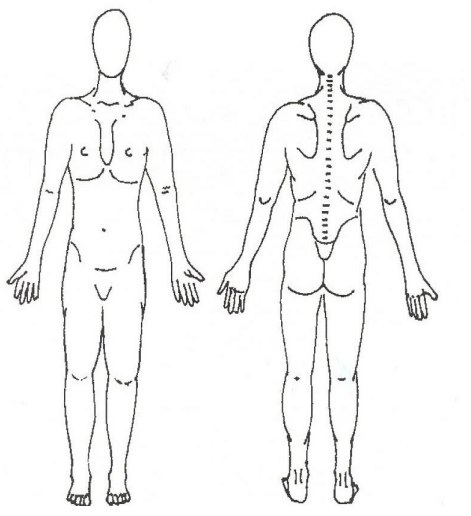
In the past week on average how often have your symptoms been present?
(Intermittent) 0-25% 26-50% 51-75% 76-100% (Constant)

In the past week how often has you pain interfered with your daily activities?
(work, social or household chores)
0 1 2 3 4 5 6 7 8 9 10

Please rate your pain (10 being the worst)
1 2 3 4 5 6 7 8 9 10

			(Please Explain)
Have you ever been injured in a motor vehicle accident?	Yes	No	_____
Have you ever been injured on the job before?	Yes	No	_____
Have you ever had a similar condition or injury before?	Yes	No	_____
Have you been treated by another doctor for this condition?	Yes	No	_____
Do you have any surgical implants (Metal plates, pacemaker)	Yes	No	_____
Do you have family history of diabetes, heart disorders, kidney disorders, back trouble, or cancer?	Yes	No	_____

PLEASE MARK YOUR AREAS OF PAIN



EXPERIENCE WITH CHIROPRACTIC

Have you been adjusted by a Chiropractor before Y or N

Reason for those visits? _____

Doctor's name_____

Approximate date of last visit _____

AUTHORIZATION AND ASSIGNMENT FORM

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 authorized the direct payment to you of any sum I now or hereafter owe you, by attorney, out of the proceeds of any settlement of my case, and/or 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 refused 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 in my name 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 a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Connecticut.
5. In the event of an unpaid account, if the account is transferred to a collection agency, I hereby agree to pay any and all collection fees and/or attorney fees. Accounts sent to a collection's agency will be assessed a collection fee not to exceed 15% of the outstanding balance.
6. I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full.
7. This authorization for assignment will be in continual effect until revoked by both parties.

Patient/Insured Signature: _____ Date:_____

I understand that all services are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand 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 for professional service rendered to me will be immediately due and payable. I authorize the use of signature on any insurance submissions.

Signature: _____ Date: _____