Waldwick Family Chiropractic
Kyle Robertson, D.C.
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waldwickchiropractic.com

Confidential Case History Record

Name_____ Male __ Female __ Today's Date _____

Nickname_____ Date of Birth _____ Age____ Height (In Inches)____ Weight____

Address_____

City _____ State_____ Zip_____ SSN _____

Email_____ Phone Number_____

Would you like to receive e-mail appointment reminders? **Y** **N**

Emergency Contact_____ Relation_____ Phone_____

How did you hear about our office? _____

When did your condition begin? _____

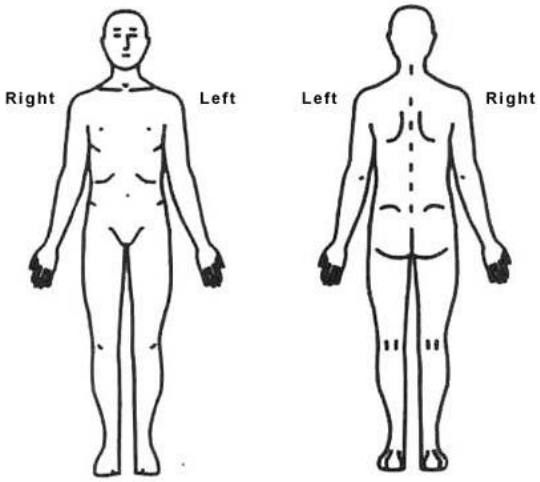
Other doctors seen for this condition? _____

Have you had the same or similar condition before? **Y** **N** Date of prior condition_____

List Chief Symptoms in Order of Severity

1.) _____
2.) _____
3.) _____

Mark Areas of Pain on Figures Below



Have you ever had chiropractic care before? **Y** **N**

Primary Care Physician_____

May we forward findings to your doctor? **Y** **N**

Current Medications_____
_____
_____

Allergies_____

Previous Surgeries_____

Personal History of Cancer, Heart Disease, Stroke, or Diabetes? **Yes** (_____) **No**

Please circle all symptoms that apply to you:

Headaches	Tingling/Numbness	Chest Pain	Unexpected Wgt. Loss
Neck Pain	Knee Pain	Fatigue	Fatigue
Back Pain	Loss of Balance	Dizziness	Hip Pain
Shoulder Pain	Shortness of Breath	Fever	Blood in Urine
Other_____		Night Pain	Pain unrelieved

For Women:

Is there a chance you may be pregnant? **Y** **N** Are you taking Birth Control? **Y** **N**

Health Insurance

Policy Holder Name_____ Date of Birth_____

Policy ID #: _____

Workers Compensation

Is your condition due to an Employment Related Injury? **Y N** Have you Reported it? **Y N**

Auto Accident

Is your condition due to an Automobile Accident? **Y N** Date of Accident_____

Auto Accident Insurance Name _____ Claim # _____

Adjuster Name _____ Phone # _____

Attorney name _____ Phone # _____

Insurance Information, Consent of Professional Services and Release of Information

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credit to my account upon receipt. However, I clearly understand and agree that all services rendered to me and are charged directly to me and that I am personally responsible for payment. I also understand 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. Jesse J. Suess, Suess Family Chiropractic LLC, and their affiliated providers to administer treatment, physical examination, X-Ray Studies, laboratory procedures, chiropractic care, acupuncture, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the service of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy, modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, but not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Suess Family Chiropractic, LLC for any reason, I will be responsible for payment of my entire outstanding balance.

We Invite you discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____ **Date**_____

Consent to Treat a Minor

I (we) being the parent, guardian or custodian of the minor being _____, age_____, do hereby authorize, request & direct Suess Family Chiropractic, LLC, it's doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue care described above as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed_____

Witness_____