

**CONFIDENTIAL CHIROPRACTIC PATIENT CASE HISTORY**  
**DR. KAREN S. THOMASON, D.C.**

DATE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ TDL# \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE# \_\_\_\_\_ CELL PHONE # \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_

MARITAL STATUS: M S W D      HOW MANY CHILDREN? \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

SPOUSE \_\_\_\_\_ EMPLOYER \_\_\_\_\_ PHONE# \_\_\_\_\_

NEAREST RELATIVE \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

PUPOSE OF THIS APPOINTMENT? \_\_\_\_\_

WHEN DID THIS PROBLEM BEGIN? \_\_\_\_\_ IS IT ACCIDENT RELATED? \_\_\_\_\_

IS THERE ANYTHING YOU CAN DO TO RELIEVE THE PROBLEM? YES \_\_\_ NO \_\_\_ IF YES PLEASE DESCRIBE \_\_\_\_\_

IF NO, WHAT HAVE YOU TRIED THAT HAS NOT HELPED? \_\_\_\_\_

WHAT MAKES PROBLEM WORSE?  
STANDING \_\_\_ SITTING \_\_\_ LYING \_\_\_ BENDING \_\_\_ LIFTING \_\_\_ TWISTING \_\_\_ OTHER \_\_\_\_\_

HAVE YOU EVER HAD ANY BROKEN BONES? YES \_\_\_ NO \_\_\_ IF YES DESCRIBE \_\_\_\_\_

HAS A PHYSICIAN TREATED YOU FOR ANY HEALTH CONDITION IN THE LAST YEAR? YES \_\_\_ NO \_\_\_ IF YES DESCRIBE \_\_\_\_\_

SERIOUS ILLNESSES (INCLUDE DATES) \_\_\_\_\_

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? \_\_\_\_\_

WHAT SURGERIES HAVE YOU HAD? (INCLUDE DATES) \_\_\_\_\_

WOMEN ONLY: ARE YOU PREGNANT OR IS THERE ANY POSSIBILITY YOU MAY BE? YES \_\_\_ NO \_\_\_ UNCERTAIN \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractic office. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will immediately be due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

PATIENT SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_