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

Have you made a report of your accident to your employer? ☐ Yes ☐ No

Do you plan on turning it in on worker's compensation? ☐ Yes ☐ No

Are you now or have you ever been disabled (service or work)? ☐ Yes ☐ No

Spinal Exam________________

Disc Exam________________

Lab Exam________________

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	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brothers No. of _____	☐	☐	☐	☐	☐
Sisters No. of _____	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

_____ Appendicitis
_____ Pneumonia
_____ Rheumatic Fever
_____ Polio
_____ Tuberculosis
_____ Whooping Cough

_____ Anemia
_____ Measles
_____ Mumps
_____ Chicken Pox
_____ Diabetes
_____ Cancer

_____ Heart Disease
_____ Goiter
_____ Influenza
_____ Pleurisy
_____ Alcoholism
_____ Venereal Disease

_____ Arthritis
_____ Epilepsy
_____ Mental Disorder
_____ Lumbago
_____ Eczema

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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 X__________ 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__________