

INFORMATION REQUIRED FOR CASE HISTORY FILE (PLEASE PRINT)

1. Male Female Primary Care Physician _____
Referring Physician _____
_____ Weight _____
Patient's Last Name First Middle
Birth Date _____ Age _____ Social Security Number _____
Address _____
City _____ State _____ Zip _____ Home Phone _____
Employer _____ Work Phone _____

2. What are your symptoms: _____

3. **Medical Coverage Information – Please Present Your Insurance Card**

Primary Insurance Co _____ **ID#** _____ **Group#** _____
Subscriber's Name _____ Birth Date _____ Male Female
Subscriber's Employer _____

Secondary Insurance Co _____ **ID#** _____ **Group#** _____
Subscriber's Name _____ Birth Date _____ Male Female
Subscriber's Employer _____

4. **Were you Injured.....** at work automobile accident other accident/injury*

Date of Injury _____ Claim# (if known) _____
Insurance Carrier _____ Adjuster _____
Address _____ Phone Number _____
Employer when injured _____ Phone Number _____
(Required for Worker's Compensation only)

*Briefly explain "Other" accident/injury _____

5. **Responsible Party for Patient under 18 Years of Age**

Name _____ Birth Date _____ Male Female
Relationship _____ Social Security Number _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
If different from above

Employer _____ Work Phone _____