

Please type into the fields on this form using your computer keypad.  
Once you have completed the form, please print it and bring it with you to your appointment.

**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 \_\_\_\_\_