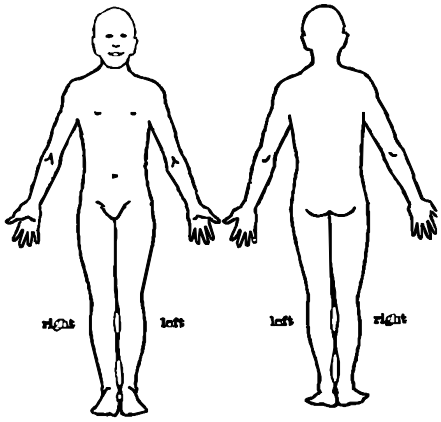
CASE HISTORY

CLARK CHIROPRACTIC CLINIC
6015 East State Street
Fort Wayne, IN 46815

Date_____
Name_____ Date of Birth_____ Age____ Sex: M F
Address_____ Phone (home)_____
City_____ Zip Code_____ Marital status: S M D W # of children___
Occupation_____ Employer_____ Phone (work)_____
Spouse's Name_____ Spouse's Occupation/Employer_____
Referred by_____ Past chiropractic care: Yes___ No___ When____ Results_____
Family Doctor_____ Phone_____
Email Address:_____Health Newsletter? Yes____ No____

CHIEF COMPLAINT 1. _____ How Long:_____
2. _____ How Long:_____
3. _____ How Long:_____

MARK AREA OF PAIN



SEVERITY OF PAIN

On a scale of zero to ten, I rate my pain as follows:

No pain Severe pain
0 _____ 10
Mark an X on the line to estimate your level of pain

* Is this visit due to an accident or on-the-job injury? Yes ___ No____
If yes, please fill out the Accident form on the reverse side.

MEDICAL HISTORY: Place an ***X*** in the field if you have ever had these conditions.

___Cancer	___Diabetes	___Polio	___ Rheumatic Fever
___Tuberculosis	___Heart Disease	___High Blood Pressure	___Anemia
___Arthritis	___Seizure Disorder	___Venereal Disease	___Concussion
___Dizziness	___Digestive Disorder	___Asthma	___Sinus Trouble
___Numbness	___Other: _____		

Describe past operations_____ Date(s)_____
Have you been treated by a physician for a health condition during the past year? Yes ___ No___
Describe condition_____ Have you ever had X-rays? When?_____
Are you taking medication?_____ What kind:_____

INSURANCE COMPANY_____ Policy/Group #_____
Social Security Number_____ Spouse's insurance co._____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's 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 the doctor's office will be credited to my account upon 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 hereby authorize the doctor to examine and treat my conditions as he deems appropriate.

Patient's signature_____ Date_____