

**Personal Information**

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_

Work Phone: \_\_\_\_\_ Emergency contact/Phone: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

**Primary Insurance**

Insurance Company: \_\_\_\_\_ Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Relationship \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_ Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Relationship \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Attorney Information --- If Personal Injury Case**

Atty Name \_\_\_\_\_ Firm \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

## Primary Physician Information

Doctor's Name: \_\_\_\_\_ Office Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Approx. date of last visit \_\_\_\_\_

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Please fill out the following section if accident related:

### Auto Information

Company \_\_\_\_\_ Phone # \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Date of Accident \_\_\_\_\_

### Worker's Comp Information

Date of Accident \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Date the accident was reported \_\_\_\_\_

To whom was the accident reported \_\_\_\_\_

Worker's Comp Insurance Carrier \_\_\_\_\_

Phone # \_\_\_\_\_ Adjuster's Name \_\_\_\_\_

Claim # \_\_\_\_\_

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Who can we thank for referring you to our office? \_\_\_\_\_

Have you ever had Chiropractic care in the past? \_\_\_\_\_

If yes, how long ago? \_\_\_\_\_ By whom? \_\_\_\_\_

**To our valued patient's:** In order to keep the cost of your healthcare at a moderate price, Sexton Chiropractic is a zero balance facility. This means we do not bill our patient's or send monthly statements. Co-pay or Coinsurance is due on each visit.

**Scheduling Appointments:** Sexton Chiropractic understands that sometimes circumstances prevent our patient's from keeping their scheduled appointments. If you cannot keep your regularly scheduled appointment please notify our office 24 hours in advance so that others in need can take your appointment slot. Also, if you are running more than 10 minutes late for your scheduled appointment, please notify our office. Thank you.

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

### Confidential Case History

O - Occasional  
 F - Frequent  
 C - Constant

Please use the frequency above and check off any of the following symptoms that you have experienced in the past year. If the symptom does not pertain to you, leave it blank.

	O	F	C		O	F	C		O	F	C	
Allergy	-	-	-	Belching/Gas	-	-	-	Hard arteries	-	-	-	
Chills	-	-	-	Colitis	-	-	-	high bld pres	-	-	-	
Convulsions	-	-	-	Colon Trouble	-	-	-	low bld pres	-	-	-	
Dizziness	-	-	-	Constipation	-	-	-	heart pain	-	-	-	
Fainting	-	-	-	Diarrhea	-	-	-	bad circulation	-	-	-	
Fatigue	-	-	-	Digestion	-	-	-	fast heartbeat	-	-	-	
Fever	-	-	-	Abdomen	-	-	-	slow heartbeat	-	-	-	
Headache	-	-	-	Hunger	-	-	-	swollen ankles	-	-	-	
Loss of Sleep	-	-	-	Gall Bladder	-	-	-				<b>O F C</b>	
Weight Loss	-	-	-	Hemorrhoids	-	-	-	Chest Pain	-	-	-	
Nervous	-	-	-	Intestine worm	-	-	-	chronic cough	-	-	-	
Depressed	-	-	-	Jaundice	-	-	-	diff. breathing	-	-	-	
Neuralgia	-	-	-	Liver trouble	-	-	-	spit up blood	-	-	-	
Numbness	-	-	-	Nausea	-	-	-	spit up phlegm	-	-	-	
Sweats	-	-	-	Stomach pain	-	-	-	wheezing	-	-	-	
Tremors	-	-	-	poor appetite	-	-	-				<b>O F C</b>	
			<b>O F C</b>	Vomitting	-	-	-	boils	-	-	-	
Arthritis	-	-	-	Vomit blood	-	-	-	bruise easily	-	-	-	
Bursitis	-	-	-				<b>O F C</b>	dryness	-	-	-	
Foot trouble	-	-	-	Asthma	-	-	-	hives/allergy	-	-	-	
Hernia	-	-	-	Colds	-	-	-	itching	-	-	-	
Pain:				crossed eyes	-	-	-	skin rash	-	-	-	
Low Back	-	-	-	Deafness	-	-	-	varicose veins	-	-	-	
Neck	-	-	-	Dental Decay	-	-	-				<b>O F C</b>	
Shoulders	-	-	-	Earache	-	-	-	bed wetting	-	-	-	
Arms	-	-	-	Ear Discharge	-	-	-	blood in urine	-	-	-	
Elbows	-	-	-	Ear Noises	-	-	-	freq. urination	-	-	-	
Hands	-	-	-	Glands	-	-	-	kidney infect.	-	-	-	
Hips	-	-	-	Thyroid	-	-	-	kidney stones	-	-	-	
Legs	-	-	-	Eye Pain	-	-	-	urination pain	-	-	-	
Knees	-	-	-	Failing Vision	-	-	-	prostate prob.	-	-	-	
Feet	-	-	-	Far sighted	-	-	-					
Tailbone	-	-	-	Gum trouble	-	-	-	For women:			<b>O F C</b>	
Poor Posture	-	-	-	Hay fever	-	-	-	Breast pain	-	-	-	
Sciatica	-	-	-	Hoarseness	-	-	-	cramps	-	-	-	
Spinal Curve	-	-	-	nasal block	-	-	-	heavy flow	-	-	-	
Swollen Joints	-	-	-	Near sighted	-	-	-	hot flashes	-	-	-	
				Nose bleeds	-	-	-	irregular cycle	-	-	-	
				Sinus infection	-	-	-	menopausal	-	-	-	
				Soar throat	-	-	-	discharge	-	-	-	
				Tonsillitis	-	-	-	Pregnant	yes	_____	No	_____

**Please circle the follow conditions you have or have had:**

Cancer	Cold sores	Goiter	Measles	Rheumatic fever	Epilepsy
Anemia	Diabetes	Gout	Miscarriage	Scarlet fever	Venerial disease
Appendicitis	pneumonia	heart disease	mult.sclerosis	stroke	Whooping cough
exzema	HIV/AIDS	mumps	turberculosis	arthritis	Polio
emphysema	influenza	pleurisy	ulcers	fever blisters	arteriosclerosis

**Tell us about why you are here today:**

What is your **major** complaint? \_\_\_\_\_

When did it start? \_\_\_\_\_ How did it start? gradually\_\_\_ suddenly\_\_\_

Explain: \_\_\_\_\_

Have you ever had this same or a similar condition in the past? yes\_\_\_ no\_\_\_

What aggravates your condition? (ex: bending, lifting, etc.) \_\_\_\_\_

What brings relief? (ex: rest, ice, etc.) \_\_\_\_\_

How does it feel? (cicle) sharp achy dull deep stabbing stinging burning numb tingling crawling

Does it radiate to any other part of your body? yes\_\_\_ no\_\_\_ If yes, where? \_\_\_\_\_

With 0 representing no pain at all and 10 representing severe pain, please rate your pain: \_\_\_\_\_

When is the pain at its worse? (upon waking, with movement, etc.) \_\_\_\_\_

What past injuries may have caused this condition? (ex: accident, falls, sports injuries, etc.)  
\_\_\_\_\_

What (if any) other doctors have you seen for this condition? \_\_\_\_\_

Briefly describe your occupational duties: \_\_\_\_\_

Have you ever fractured a bone? yes\_\_\_ no\_\_\_ If yes, which one and when? \_\_\_\_\_

List any past surgeries: \_\_\_\_\_

Family Health History (parents, sibblings) if relevant: \_\_\_\_\_

Please list any medications you are presently taking (be sure to include over the counter medications and vitamins). \_\_\_\_\_  
\_\_\_\_\_