



Marcus Family Chiropractic

PLEASE CIRCLE METHOD OF PAYMENT

Visa/MC Cash Check

Please Print

Date _____

Name _____ SS# _____ Phone# _____ Cell _____

Address _____ City _____ State _____ Zip _____

D.O.B. _____ Age _____ Marital Status _____ # Of Children _____ Work# _____

Occupation _____ Employer _____

Name Of Spouse _____ Occupation _____

Employer _____

How Did You Hear Of This Office?(Be Specific): Friend _____ Sign _____

Newspaper _____ T.V. _____ Radio _____ Other _____

Email: _____

Chief Complaint _____

Area Of Problem _____ Work Related? Y N

Date of Onset _____ Sudden or Gradual? _____

Duration of Problem: Min. Hours Days Months Years (circle one)

Pattern of Problem: (check one)

Constant _____ intermittent _____ Occasional _____

Initiating Factors _____

What Makes It Better? _____

What Makes It Worse? _____

Past History

Please List All Previous Surgeries/Fractures: _____

Current Medications: _____

Have You Ever Been involved in an Automobile Accident? **Y N** Explain: When? _____
Injuries _____

Have You Ever Had A Serious Fall Or Other Type Of Accident? **Y N** When? _____
Injuries: _____

Present M.D. & Address: _____

Date of Last Visit: _____ Reason _____

Previous Chiropractor & Address _____

Date Of Last Visit _____ Reason _____

Are You Pregnant? **Y N** Date of Your Last Monthly Period _____

Do You Use Any Of the following? (circle all that apply)

Tobacco Alcohol OTC Drugs Caffeine Sweeteners

FAMILY HISTORY (check all that apply)

- ()Heart Disease ()Cancer ()Osteoporosis ()Diabetes ()Stroke ()Epilepsy
()Bone Malformation ()Asthma ()Hypertension

I, _____, have reviewed and agree with the comments included in this case history.

Terms of Acceptance

To assure proper chiropractic care, the chiropractor and the patient must agree upon the goals of chiropractic.

I fully understand that the straight chiropractor services that I will receive at Marcus Family Chiropractic Center are in no way intended as a substitute for standard medical care. I understand that Chiropractic is a health care profession dealing specifically with the correction of vertebral subluxations, as they are responsible for the interference of mental impulses throughout my body and interfere with my body's innate abilities to keep me healthy and in a state of ease. It has been explained to me that the objective of the chiropractor is to locate, analyze and correct vertebral subluxations. The correction of these subluxations is not for the purpose of treating specific diseases, symptoms or conditions. I understand that my health is my responsibility and if I wish to seek alternative health care this is my right to do so.

Patient _____ Witness _____

Doctor _____ Date _____

If Patient Is a Minor

Please be advised that my son/daughter _____ has my permission to be under chiropractic care at Marcus Family Chiropractic, Bethlehem, PA.

ARE YOU INTERESTED IN KNOWING ABOUT OUR "FAMILY PLAN" SO THAT YOU AND YOUR FAMILY CAN MAINTAIN BETTER HEALTH? YES NO

