Marcus Family Chiropractic

820 Eaton Avenue, Bethlehem, PA 18018 / (610) 974-8900 / www.chiromom.com

PLEASE CIRCLE METHOD OF PAYMENT

Visa/MC/Discover HSA/FSA cash check

(please print)

Date_____

Name_____Cell Phone#_____ Home Phone#_____

Address_____City_____State____Zip_____

D.O.B._____Age____Marital Status____# of Children____Work#_____

Occupation_____Employer_____

Name of Spouse_____Occupation_____

Employer_____

Emergency Contact_____Relationship_____Phone#_____

How did you hear about this office? (Be specific): Friend_____Sign_____

Newspaper_____T.V._____Radio_____Other_____

Email_____Communication Preference?_____

Chief Complaint:

Area of Problem_____Work Related? Y N

Date of Onset_____ Sudden/Gradual(circle one) Pain Scale 0-10(10 worst)_____

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

Pattern of Problem: (check one)

Constant___ Intermittent___ Occasional___

Initiating Factors _____

_____

_____

_____

What makes it better? _____

_____

_____

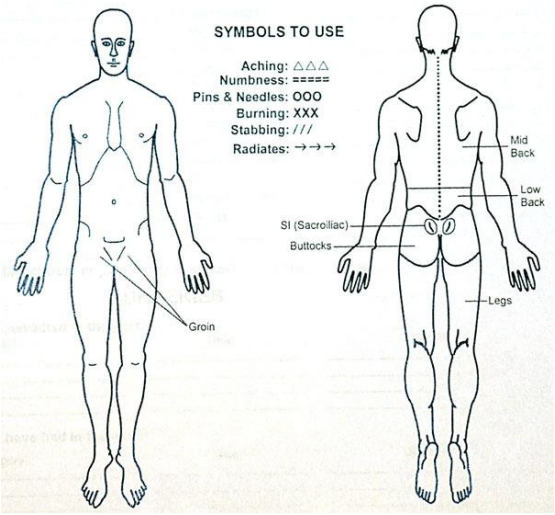
_____

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 When? _____
Injuries: _____
_____
Have you ever had a serious fall or other type of accident? Y N When? _____
Injuries: _____
_____
Present M.D. and address: _____
Date of last visit: _____ Reason: _____
Previous Chiropractor and address: _____
Date of last visit: _____ Reason: _____
Date of your last monthly period: _____ Are you pregnant? Y N
Do you use any of the following? (circle all that apply)

Tobacco Alcohol OTC Drugs Caffeine Sweetners

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 LEARNING ABOUT OUR "FAMILY PLAN" SO THAT YOU AND YOUR FAMILY CAN MAINTAIN BETTER HEALTH? YES NO

_____

For Office Use Only

CF&SNZ___TKO___ER___STTCHS___BM___WTR___PLA___PLW___SLP___SNR___Hg___CVP___