Schmit Chiropractic Offices, LLC
Dr. Ed Schmit **Dr. Shaun Roberts**
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CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION Date ____________

Name ______________________ Home Phone ________ Cell ________
First MI Last

Mailing Address ______________ ________ ________ ____ ____ - ____
Street Apt. # City State Zip + 4 digits

Sex: ☐ Male ☐ Female Birth date ________ Age ____

Marital: M S W D How Many Children? ____

Social Security # ____________ E-Mail Address ____________

Occupation ____________ Employer ____________

Address ______________________ Office Phone ____________
Street City State Zip

Name of Husband or Wife ____________ Occupation ____________

Employer ____________ Address ______________________
Street City State Zip

In Case Of Emergency, Contact:

Name ____________ Relationship ________ Phone ________

Referred by ____________ Relationship ________

Is the condition due to an accident? Yes ____ No ____ Date of Accident ________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other ____________

Number of days lost from work ____ Date symptoms appeared ________

Have you ever had the same or similar condition? ☐ Yes ☐ No If yes, when and describe ________

____

Have you ever seen a chiropractor before? ☐ Yes ☐ No When ____________

Date of last physical examination ____________

What operations have you had? ____________ When? ________

Serious illness ____________ When? ________

Have you ever suffered from:

☐ Dizziness ☐ Cancer ☐ Asthma ☐ Sinus Trouble ☐ Diabetes
☐ Backaches ☐ Arthritis ☐ Neuritis ☐ Heart Trouble ☐ Numbness
☐ Anemia ☐ Headaches ☐ Nervousness ☐ Rheumatic Fever ☐ Digestive Disorders

Purpose of this appointment ____________

Other doctor seen for this condition ____________ Where? ________

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe ____________

What medications or drugs are you taking? ____________

____

Are you pregnant? ☐ Yes ☐ No

Person responsible for account ____________ Birth date ________

Address ______________________
Street City State Zip

Phone No. ____________

Patient's Signature ____________ Date ________

Guardian's Signature Authorizing Care ____________ Date ________

(If you are covered by insurance, see other side.)