PATIENT CASE HISTORY

T.J. NUGENT DC, PLC

NAME:	Email:	DATE:
ADDRESS:	CITY/STATE:	APT #

ZIP CODE:	Home Phone:( ) Work:( ) Cell:( )	DATE OF BIRTH:	AGE:

□ MARRIED □ WIDOWED □ SINGLE □ DIVORCED	□ MALE □ FEMALE	NO. OF CHILDREN:	OCCUPATION:

DO YOU HAVE HEALTH INSURANCE? (If yes, please give company name, address & phone number):
□ YES Company:
□ NO Address: Phone: ( )

INSURED'S NAME:	INSURED'S ADDRESS/ PHONE: (If same as patient, leave blank)
INSURED'S EMPLOYER:	ID # GROUP/ POLICY #

SOCIAL SECURITY #	REFERRED BY:	HAVE YOU HAD CHIROPRACTIC CARE BEFORE? □ YES WHERE/ WHEN ? □ NO

WHAT IS YOUR MAJOR COMPLAINT?	JOB DESCRIBTION:
_____	_____
_____	_____
_____	_____

ARE YOU ON MEDICARE? □ YES, MEDICARE # _____ □ NO	ARE YOU ON MEDICAID? □ YES, MEDICAID# _____ □ NO

INDICATE IF YOU ARE HERE FOR CARE BECAUSE OF: □ ON THE JOB INJURY □ AN AUTO ACCIDENT □ A HOME INJURY	DATE INJURED:_____ INSURANCE CO:_____ ATTORNEY'S NAME:_____ ATTORNEY'S PHONE:_____ ATTORNEY'S ADDRESS:_____

HAVE YOU EVER HAD ANY FALLS, AUTO ACCIDENTS OR INJURIES? □ YES □ NO	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

HAVE YOU EVER HAD SURGERY? □ YES □ NO	MONTH, YEAR	TYPE OF SURGERY	COMMENTS

ARE YOU PRESENTLY TAKING MEDICATION? □ YES □ NO	DRUG	DOSES PER DAY	LENGTH OF TIME TAKING

2931 MANOR DRIVE MIDLAND, MI 48640 (989)-835-8330
FAX: (989)-835-4906 E-MAIL: tjnugentdc@yahoo.com

WWW.TJNUGENTDC.COM