Date ______________

David Bennett Lytch, D.C.
Doctor of Chiropractic

Confidential Case History

Dear prospective new patient,

Please complete this information to the best of your ability. Your answers will help us to determine if you are a candidate for chiropractic care. If we do not sincerely believe your condition will respond well, we will not accept your case. Thank you for your assistance.

General Information **(Please Print Clearly)**

Name ______________________________ Address ______________________________

City ____________ State ____ Zip ______ Social Security # ____________ Home Phone __________

Place Of Employment __________________ Position ________________ Work Phone # __________

Birth date __________ Age _____ Male __ Female __ Marital Status: M S D W Number of Children ___

- -

Spouse's Name (or parent) __________________ Social Security # __________ Home Phone __________

Spouse's (or parent's) Place Of Employment ____________________

How were you referred to our office? ____

Health Information

Reason for consulting this office: __ Specific Symptom or Problem

__ Preventing Illness and Disease

__ Maximizing Personal Health Potential

What is your major complaint? ____________________________ For how long? ______________

Has this ever happened before? _______ When? ____

Was it as bad as this episode? __ Not as bad __ About the same __ Worse this time

Other doctors consulted for this condition: __________________________ Results: _________________

Have you had previous chiropractic care? ______ When? _________ By whom? ____________________

Was this chiropractic treatment for your current complaint or another? ______________________________

Is this condition interfering with your: Work _____ Sleep _____ Daily Routine _____ Exercise _____

What does this condition prevent you from doing? ____

Please list surgeries and dates ____

Please list any medications you now take ____

Age of mattress ________ ___ Comfortable ___ Uncomfortable ___ Water Bed

Please check if you are wearing: __ Heel Lifts __ Arch Supports **Are you pregnant?** ________

Have you been in an auto accident: __ Lately __ Past Year __ Past Five Years __ Over Five Years __ Never

Please Describe ____

Any other injury or accident: __ Lately __ Past Year __ Past Five Years __ Over Five Years __ Never

Please Describe ____

<Continued on other side>

Past Health History

Do you now or frequently suffer from any of the following:

__ Headaches	__ Hay Fever	__ Elbow Pain	__ Indigestion	__ Bed Wetting
__ Nervousness	__ Sore Throats	__ Arm Pain	__ Hiatal Hernia	__ Impotency
__ Insomnia	__ Neck Stiffness	__ Wrist Pain	__ Kidney Troubles	__ Knee Pains
__ Chronic Fatigue	__ Shoulder Pain	__ Arm Numbness	__ Skin Conditions	__ Low Back Pain
__ Dizziness	__ Upper Arm Pain	__ Carpal Tunnel	__ Constipation	__ Sciatica
__ Nausea	__ Chronic Colds	__ Rapid Heart Rate	__ Diarrhea	__ Leg or Hip Pain
__ Sinus Troubles	__ Thyroid Problems	__ Liver Problems	__ Gas	__ Numbness in Legs
__ Allergies	__ Asthma	__ Anemia	__ Stomach Cramps	__ Poor Circulation
__ Ear Infection	__ Chronic Cough	__ Stomach Troubles	__ Bladder Troubles	__ Hemorrhoids
Woman __ PMS	__ Irregular Cycle	__ Painful Periods	__ Excessive Flow	__ Hot Flashes
Children __ Bed Wetting	__ Growing Pains	__ Ear Infections	__ Frequent Colds	__ Inverted Foot

Occupational Activities

Please describe your Job: ____

Which of the following activities does your job require you to do often? __ Lifting __ Pulling __ Pushing __Twisting __ Bending __Computer Use __ Typing __ Answering Telephone __ Standing

Exercise __ None __ Moderate __ Daily **Type**: __ Walk __ Run __ Aerobics __ Weights __ Other

Habits __ Smoking __ Packs/Day __ Coffee __ Cups/Day __ Alcohol __ Amount/Day

Hobbies Sports ______________________ Home Activities ______________________

Outdoor Activities ______________________ Other ______________________

Diet __ Very Healthy __ Watch what I eat __ I don't worry about diet __ Unhealthy

Payment Information

IT IS THE POLICY OF THIS OFFICE THAT ALL VISITS BE PAID IN FULL AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

Is this injury related to an automobile accident, a work related injury, or an injury involving someone else's insurance? (If yes, please tell our front desk)

AUTHORIZATION TO ADMINISTER CARE

I authorize the attending doctor to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. INIT _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim and I also certify that all information given to this office is correct and complete. INIT _____

X-RAY NOTE: The amount paid for radiographic films is for examination only, and the films will remain the property of this office, on file, where they may be seen at any time. INIT _____

CONSENT TO TREAT MINOR CHILD: I hereby authorize the doctor to administer chiropractic care as deemed necessary to my child, ______________________.

Legal Guardian: ______________________ Date: ___________ Signature:

I have read the information stated above and have answered everything truthfully and to the best of my knowledge.

Signature: ______________________________ Date: ______________