CASE HISTORY

Name	THE PERSON NAMED IN POST OF PERSONS AND PERSONS	Date	Case Number
Address		City	State Zip
Phone (Home)	Date Of Birth Se	x: M F Marital Status: S	M D W # Children
Occupation	Employer	Telephone	(Work).
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Have you retained an attorney?	□ No □ Yes Name & Ad	dress	
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390 Rheumatic Fever	0072 Mumps	Q 487 Influenza	☐345 Epilepsy ☐319 Mental
O45 Polio	052 Chicken Pox	☐ 511 Pleurisy	Disorder
O 011 Tuberculosis	250 Diabetes	305.0 Alcoholism	□724.2 Lumbago
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Thereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understored and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of the office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosed.

Date

Patient's/Guardian's Signature X