JEFFREY SCHLESINGER, D.C., C.F.T., C.C.I.C.
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PATIENT CASE HISTORY:

Name:_____

Address:_____

_____

Telephone: (Home)_____(Cell)_____(Work)_____

E-Mail_____ Age:_____ Birth date_____ Marital Status: S M W D

Occupation:_____

Referred to this office by:_____

----------HEALTH INFORMATION----------

What is your major complaint?_____

How long have you had this condition/ symptom?_____

Have you had this condition in the past? If so, how often?_____

_____

Is this condition/ symptom getting worse?_____

Is this condition/ symptom constant in nature?_____

Does this condition/ symptom interfere with any daily activities such as work, sleep, daily routine, exercise?

(Explain)_____

_____

Have other physicians treated this condition/ symptom? (Explain)_____

_____

Have you ever been treated by a Chiropractor? If so, when was your last visit and what were you treated for?_____

_____

(**TURN OVER AND CONTINUE**)

Have you had any surgical operations? If so, (Explain)_____

_____

Do you take any drugs/ medications? If so, what?_____

_____

Are you wearing any appliances/ orthotics in your footwear? _____

Have you ever been in an automobile accident and/ or had any other accidents/ injuries? If so, when?

(Explain)_____

_____

Have you or do you presently suffer from? If yes, please circle:

Dizziness, Backaches, Heart Trouble, Diabetes, Arthritis, Headaches, Neck Pain, Asthma,

Nervousness, Digestive Disorders

Have you ever or do you presently suffer from any serious illnesses? Is so, (Explain)_____

_____

PAYMENT POLICY:

*** **DUE TO STRICT MANAGED CARE REGULATIONS,**
ALL FEES including Insurance Co-payments, Co-insurance and **Deductibles (if applicable)** cannot and will not be billed. These fees are due on the day of service in the form of **cash, check, credit or debit card**. While all services rendered at this office are completely based upon medical necessity, any denial of services by an insurance carrier **(if applicable)** which they deem not to be medically necessary and/ or non covered services based upon an individuals plan guidelines will be the complete obligation of the patient.

***Missed Appointments/ Cancellation Policy:**
To maintain my policy of granting substantial and appreciable time to all patients and clients as well as for common courtesy and respect, all appointments which have been scheduled in advance and cannot be attended require a courtesy cancellation by phone, text or e-mail. A **$75.00 NO SHOW FEE** will be required before any further appointments will be scheduled. Please note, the foregoing fee will be the complete obligation and responsibility of the patient and/ or client and is not a insurance billable fee.

***I have read and agree to abide by above office payment policy:**

_____ _____
Patient's Signature Date