



CASE HISTORY UPDATE

In order for us to best serve to you, please provide the following Information and indicate if this is WORK or AUTO related before completing. If your insurance or demographics have not changed, you may skip that section. THANK YOU! **PLEASE PRINT**

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____ SSN: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____

Primary Care Physician: _____ Phone#: _____

Doctor's Address: _____

Since your last office visit here, have you consulted another doctor? Yes No

If so, give doctor's name: Dr. _____ and condition for which you were treated:

List present complaints (describe fully): _____

Duration of present complaint: _____ What do you believe caused this condition: _____

Describe any falls, surgery and/or accidents since last visit: _____

Date of last exam: _____ Date of last adjustment: _____

Describe condition(s) for which you were previously treated in this office and your response to the treatment(s): _____

Doctor Preference: Dr. Santiago Dr. Julie Both No Preference

Patient Signature (Parent if minor)