**Seim Chiropractic Center**
3951 Brown Trail
Colleyville, TX 76034
817-656-0046

Patient Account Number: ____________
Date of previous visit: ______________

## CASE HISTORY UPDATE

Legal Name: ______________________________ Date: _______________ Marital Status M S D W
Name you would prefer to be called: _______________ Spouse's name: _________________________
If a minor, list parent/guardian name: __________________________ Birthdate: _________________
Address: ________________________ City: _______________________ State: _____ Zip: _________
Phone (Home) ________________ Phone (Work) ________________ Phone (Cell) ________________
Email Address: _______________________________________________________________________
Employer: ________________________________________ Job Title: ___________________________
Emergency Contact: ________________________ Phone: _______________ Relationship: __________
Name and phone number of Primary Care Physician: _________________________________________
Insurance Company: __________________________________ Phone #: ________________________

Please describe the reason for consulting us today (list all complaints in detail): ___________________
_____________________________________________________________________________________
_____________________________________________________________________________________

When did this condition begin (date): _____________________ What caused it? __________________
_____________________________________________________________________________________

Describe any falls, accidents, surgeries or illnesses since your last visit here: ______________________
_____________________________________________________________________________________

Since your last visit here, have you consulted another doctor? Dr. _____________________________
Condition and treatment: ______________________________________________________________
_____________________________________________________________________________________

List any other information that you would like the doctor to know: ____________________________
_____________________________________________________________________________________

What was your response to previous treatment in our office? _________________________________

I authorize release of information to the following: ____________________________________________

Patient/parent/legal guardian Signature: __________________________________ Date: ___________
(*PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE*)

DOCTORS COMMENTS:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
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