

\_\_\_ Hialeah \_\_\_ Hollywood

**JOHN S. VIRGA, D.C., P.A**

**CONFIDENTIAL PATIENT CASE HISTORY**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Email \_\_\_\_\_ SS # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Marital Status M S W D No. of Children \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

If your condition is due to an auto accident please check what type

Auto \_\_\_ Employment \_\_\_ Home \_\_\_ Other \_\_\_

Date of Accident \_\_\_\_\_ Place of Accident \_\_\_\_\_

Name of Auto Ins \_\_\_\_\_ Policy # \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**

Name of Health Ins Co: \_\_\_\_\_ Group Policy # \_\_\_\_\_

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Are you or your dependent covered under any other Insurance Plan? Yes \_\_\_ No \_\_\_

Name of Insured: \_\_\_\_\_ Insurance Co Name: \_\_\_\_\_

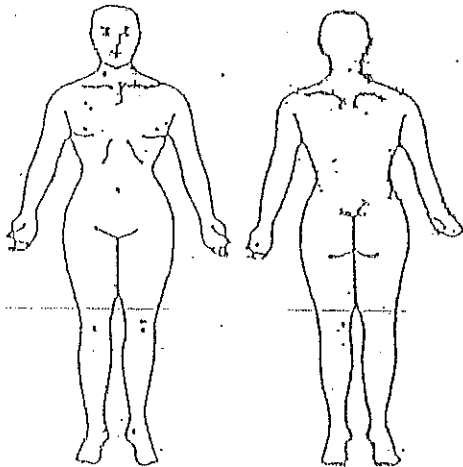
I UNDERSTAND THAT IF DETERMINED ADDITIONAL TREATMENT WILL BE NECESSARY, ALL TREATMENT, X-RAYS AND EXAMINATIONS ARE TO BE PAID AS THEY ARE RECEIVED OR DEFINITE FINANCIAL ARRANGEMENTS MADE IN ADVANCE.

Patient Signature: \_\_\_\_\_

All x-rays taken at this office become a permanent part of our records and as such will not be released.

Date of last physical examination: \_\_\_\_\_

Please mark the areas where you are  
Feeling pain on the figure below:



Have you ever suffered from?

- |                        |     |    |
|------------------------|-----|----|
| 1. Dizziness           | Yes | No |
| 2. Backaches           | Yes | No |
| 3. Heart Trouble       | Yes | No |
| 4. Diabetes            | Yes | No |
| 5. Arthritis           | Yes | No |
| 6. Headaches           | Yes | No |
| 7. Asthma              | Yes | No |
| 8. Neuritis            | Yes | No |
| 9. Digestive Disorders | Yes | No |
| 10. Nervousness        | Yes | No |
| 11. Sinus Trouble      | Yes | No |
| 12. Neck Pain          | Yes | No |

**Health Information:**

Have you had previous Chiropractic Care? \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Other Complaints: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Is this condition getting progressively worse? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the pain constant or comes and goes? \_\_\_\_\_

Is this condition interfering with you're: work \_\_\_ sleep \_\_\_ daily routine \_\_\_ other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Name of other doctors who treated this condition: \_\_\_\_\_

## ACCIDENT INFORMATION AND DETAIL FORM

Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Approximate time of accident \_\_\_\_\_ (AM PM)

Were you the driver or a passenger in the automobile?

Describe how the accident happened: \_\_\_\_\_

Were you taken to the hospital? \_\_\_\_\_ If yes, which hospital? \_\_\_\_\_

Have you received any treatment or x-rays prior to our office? \_\_\_\_\_ If yes where? \_\_\_\_\_

Were you released or hospitalized? \_\_\_\_\_ Did you receive any supports? \_\_\_\_\_

If yes what did you receive? \_\_\_\_\_

Have you ever had any previous accidents or illnesses? \_\_\_\_\_

If yes, when and where? \_\_\_\_\_

Was there any problem in the areas of complaint before the accident? \_\_\_\_\_

If yes where? \_\_\_\_\_

Is there anything else that we should know about your health? \_\_\_\_\_

If auto accident, were you wearing a seat belt? Yes No

Was a citation given to anyone? Yes No If Yes who? \_\_\_\_\_

Have you retained an attorney? Yes No

If yes, state name, address and phone number:

Attorney Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Address: \_\_\_\_\_

JOHN S. VIRGA, D.C., P.C.

Fecha: \_\_\_\_\_

HISTORIA MEDICA CONFIDENCIAL

Nombre: \_\_\_\_\_ Seguro Social # \_\_\_\_\_

Direccion: \_\_\_\_\_

Telefono: (\_\_\_\_) \_\_\_\_\_ Celular (\_\_\_\_) \_\_\_\_\_

Correo Electronico: \_\_\_\_\_ Edad: \_\_\_\_\_

Fecha de Nacimiento: \_\_\_\_\_ Estado Civil: M S W D Numero de Hijos: \_\_\_\_\_

Ocupacion: \_\_\_\_\_ Telefono de empleo: (\_\_\_\_) \_\_\_\_\_

Nombre de Empleo \_\_\_\_\_

Direccion de Empleo: \_\_\_\_\_

Si su condicion es debida a un accidente, por favor marque el tipo:

Automobilistico \_\_\_\_\_ Empleo \_\_\_\_\_ Casa \_\_\_\_\_ Otro \_\_\_\_\_

Fecha del accidente: \_\_\_\_\_ Direccion de el accidente: \_\_\_\_\_

Nombre de su seguro de carro \_\_\_\_\_ # de poliza \_\_\_\_\_

Informacion del seguro medico:

Nombre: \_\_\_\_\_ # de Poliza \_\_\_\_\_

# del Medicare: \_\_\_\_\_ # del Medicaid: \_\_\_\_\_

Esta usted o su dependiente cubierto bajo otro plan de seguro? Si \_\_\_ No \_\_\_

Nombre del asegurado: \_\_\_\_\_ Nombre del seguro: \_\_\_\_\_

# del poliza \_\_\_\_\_ #del agrupacion \_\_\_\_\_

**YO ENTIENDO QUE TODOS LOS TRATAMIENTOS, PLACAS Y EXAMENES  
TENDRAN QUE SER PAGADOS EN EL MOMENTO DE SERVICIO O OTRO  
ARREGLO POR ADELANTADO.**

Firma del paciente: \_\_\_\_\_

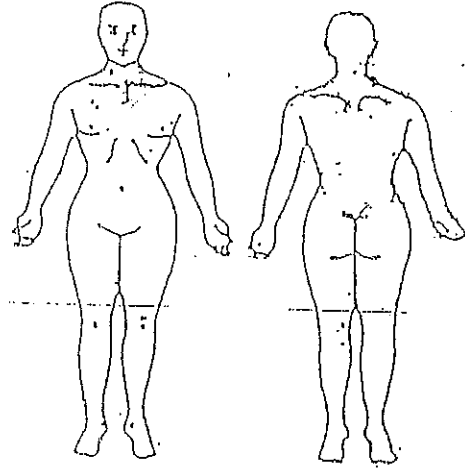
**TODAS LAS PLACAS TOMADAS EN ESTA OFICINA SON PARTE PERMANENTE  
DE NUESTRO ARCHIVOS Y NO SERAN ENTREVIGADAS.**

Fecha del ultimo examen fisico: \_\_\_\_\_

Favor marcar las areas de su dolor en las figuras:

Usted ha sufrido de:

- |                         |    |    |
|-------------------------|----|----|
| 1. Mareos               | Si | No |
| 2. Dolor del espalda    | Si | No |
| 3. Problema del corazon | Si | No |
| 4. Diabetes             | Si | No |
| 5. Arthritis            | Si | No |
| 6. Dolor de Cabeza      | Si | No |
| 7. Asma                 | Si | No |
| 8. Neuritis Rinones     | Si | No |
| 9. Problemas Digestivos | Si | No |
| 10. Nervioso            | Si | No |
| 11. Sinositis           | Si | No |
| 12. Dolor de cuello     | Si | No |



Informacion de salud:

Ha tenido cuidado quiropractico? \_\_\_\_\_

Cual es su problema ahora? \_\_\_\_\_

Otros problemas: \_\_\_\_\_

Cuanto tiempo ha tenido este problema? \_\_\_\_\_

Ha tenido esto simtomas en el pasado? \_\_\_\_\_

Cuales actividades agravan su condicion? \_\_\_\_\_

Su condicion esta empeorando? Si \_\_\_\_\_ No \_\_\_\_\_

Su Dolores son? Constante \_\_\_\_\_ va y viene \_\_\_\_\_

Le interfieren con su: Trabajo \_\_\_\_\_ Dormir \_\_\_\_\_ Rutina Diaria \_\_\_\_\_

Cuanto tiempo hace que usted no se siente bien? \_\_\_\_\_

Nombre de doctores que lo han atendido por esta condicion? \_\_\_\_\_

Informacion De Accidente

Nombre: \_\_\_\_\_

Fecha Del Accidente: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Hora Que Paso El Accidente: \_\_\_\_:\_\_\_\_ AM / PM

Usted Era El Chofer or Pasajero?  Si / No

Como Paso el Accidente: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Usted Fue al Hospital?  Si / No

Nombre de el Hospital: \_\_\_\_\_

Usted Fue Hospitalizado?  Si / No

Adone Sientes Dolor? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Antes de este accidente, usted sentia dolor en las arias que le duelen ahora?  Si / No

Usted ha recibido tratamiento, o le han tomado placas por este accidente?  Si / No

Usted ha tenido algun accidente o enfermedad antes de este accidente?  Si / No

Hay qualquier otra informacion que nosotros necesitamos saber sobre su salud?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Si su accidente fue de auto, usted tenia su cinturon puesto?  Si / No

A quien le dieron el ticket? \_\_\_\_\_

Usted tiene abogado?  Si / No

Nombre de su Abogado: \_\_\_\_\_