

**Liberty Healthcare Confidential Patient Case History**  
**2120 W. Springcreek Parkway Suite A Plano, TX 75023**  
This confidential history will be part of your permanent records.

**First Name** \_\_\_\_\_ **Middle** \_\_\_\_\_ **Last** \_\_\_\_\_

**Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age** \_\_\_\_\_ **SSN** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Gender**  Male  Female **Marital Status**  Single  Married  
**Race**  White  Black/African American  Hispanic  Other \_\_\_\_\_

**Language**  English  Spanish  Other \_\_\_\_\_  
**Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Are we able to leave a detail message on your phone lines?** Yes / No  
**Email Address** \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_  
**Are we able to email you? (No medical information will be released through email)** Yes / No

**Emergency Contact** \_\_\_\_\_ **Relationship to you** \_\_\_\_\_

**Phone Number** \_\_\_\_\_  
**Employment Status**  Employed  Student  Retired  N/A  
**Employer** \_\_\_\_\_ **Work Number** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **City** \_\_\_\_\_  
**Date of accident?** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Where did accident occur? City:** \_\_\_\_\_ **State:** \_\_\_\_\_  
**Describe the accident in your own words:**

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

**Did the ambulance EMT's examine you at the scene of the accident?** Yes / No  
**Did you go to the Hospital?** No / Yes, **Name of Hospital** \_\_\_\_\_

**Allergies: 1.** \_\_\_\_\_ **2.** \_\_\_\_\_ **3.** \_\_\_\_\_ **4.** \_\_\_\_\_ **If none, check here**   
**Current Medication: 1.** \_\_\_\_\_ **2.** \_\_\_\_\_ **3.** \_\_\_\_\_ **4.** \_\_\_\_\_ **If none, check here**

**List Surgical Operation:** \_\_\_\_\_

**Family History:** **Father Illnesses/Diseases** \_\_\_\_\_  
**Mother Illnesses/Diseases** \_\_\_\_\_

**Medical History:** Please check ALL that apply to you.  
 Muscle Pain  Loss of Sensation  Heart Trouble  
 Muscle Weakness  Poor Coordination  Stroke  
 Muscle Cramps  Weak Hand Grip  Cancer  
 Muscle Twitching  Difficulty Speaking  Depression/Anxiety  
 Joint Stiffness  Loss of Memory  Arthritis  
 Joint Pain  Migraines  Kidney Stones  
 Seizures  Mental Illness  Diabetes  
 Vertigo/Dizziness  High Blood Pressure  Bladder Trouble  
 Hand Trembling  Angina/ Chest Pain  Bowel Trouble

**Social History:**  
Caffeine Use  Heavy  Moderate  Light  N/A  
Alcohol Use  Heavy  Moderate  Light  N/A  
Smoke Use  Heavy  Moderate  Light  N/A  
Work/Job  Heavy  Moderate  Light  N/A  
Mental Work  Heavy  Moderate  Light  N/A  
Exercise  Heavy  Moderate  Light  N/A

**We use an open Therapy area. If at any time you desire privacy for therapy or private consultation please notify staff.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized credited to my account upon receipt. I permit this office to endorse to issue remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Liberty Healthcare extends credit to me and I also understand that if I suspend or terminate my care of treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctors at Liberty Healthcare and whomever they may designate as their assistant to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is correct. I authorize and assign the direct payment by an insurance company obligated to make payment based on the charges made for your service.

**Patient or Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_