Mission City Healthcare Confidential Patient Case History
815 E. Rector St. Ste 105A San Antonio, TX 78216
This confidential history will be part of your permanet 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 th 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:

Caffine 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 die 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_____