CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION DATE: ____________________

Name: ______________________________ **SS#** ____________________ **Home Phone**: ____________________

EMail: ______________________________ **Cell Phone** ____________________ **Alt Phone:** ____________________

Address: ______________________________ City: ________________ State: ______ Zip Code: ____________

Age: __________ Date of Birth: ______________ Marital Status: M S D W How Many Children? __________

Occupation: ______________________________ Employer : ______________________________

Employers Address: ______________________________ Office Phone: ________________

Name of Spouse: ______________________ Occupation: ______________________________

Spouses Employer: ______________________ Address: ______________________________

Name of Nearest Relative: ________________ Address: ______________________ Phone: ________________

Who may we thank for referring you? ______________________________

If not referred, how did you find us: *(circle one)* TV Commercial (Network__________) Facebook Health Fair Email Yelp

If from other source: *(circle one)* Public Lecture Google Yahoo Bing Website Newspaper *Other*: ____________________

Is the condition due to an injury or sickness arising out of employment ______________________________

Is the condition due to an injury or sickness arising out of an auto or other accident? ____________________

Numbers of days lost from work? ______________ Date symptoms appeared or accident happened? ______________

Have you ever had the same or similar conditions: Yes______ No______ If yes, when and describe: ______________

____

____

Date of your last physical examination: ______________ Who is your Primary Physician? ______________

Primary Physicians Address and Phone Number: ______________________________

Would you like a report on your condition to be sent to your Primary Physician? ______________________

What operations have you had? ______________________________ When: ______________

Have you ever had a serious illness? ______________________________ When: ______________

Have you ever suffered from any of the following? Check all that apply:

_____ Dizziness	_____Arthritis	_____Digestive Disorder	_____Diabetes	_____AID/HIV
_____Backaches	_____Headache	_____Nervousness	_____Asthma	_____Alcoholism
_____Heart Trouble	_____Numbness	_____Sinus Trouble	_____Anemia	_____Depression
_____Hernia	_____Neuritis	_____Rheumatic Fever	_____Cancer	_____Weight Change

Other? Please describe: ______________________________

What is the purpose of this appointment? ______________________________

Have you seen any other doctors for this condition? Yes No Who? ______________________

Type: Chiropractor MD Medications Surgery Other ______________

Has a physician treated you in the last year for any other health reason? Yes No

If yes please describe: ______________________________

Please list any medications or drugs you are currently taking? ______________________________

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself—not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company. If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE? YES NO COMPANY: ______________________________

Patients Signature: ______________________________ Date: ______________

Guardians Signature Authorizing Care: ______________________________ Date: ______________

Continued on back

Describe your major complaint and how the problem began: ____

____

Secondary Symptom: ____

Other Symptoms: ____

1. If this is a recurrence, when was the first time you noticed this problem? ______________________
   How did it originally occur? ______________________
   Has it become worse recently? _____Yes _____No _____Same _____Better _____Gradually worse
   If yes, when and how? ____
2. How frequent is the condition? ___Constant(81-100%) ___Frequent (51-80%) ___Occasional (26-50%) ___Intermediate(25% or less)
   How long does it last? _____All Day _____Few Hours _____Few Minutes
   Is your problem affecting your ability to do work or do other routine activities?______________________
   ___No Effect ___Have some restriction but can function ___Need assistance ___Can work ___Totally disabled
3. Are there any other conditions or symptoms you have that may be related to your major symptom? ____Yes ____No
   If yes, please describe ____
   Is there other unrelated health problems? _____Yes _____No
   If yes, please describe ____
4. Describe the pain: ___ Sharp ____Dull ___ Numbness ___ Tingling ___ Aching ____Burning _____Stabbing
   Other: ____
5. Is there anything you can do to relieve the problem? _____Nothing _____Walking _____Standing _____Sitting _____Moving Around or Exercise _____Lying Down
   If no, what have you tried to do that has not helped? ______________________________
6. What makes the problem worse? _____Standing _____Sitting _____Lying _____Bending _____Lifting _____Twisting _____Nothing
   Other: ____
7. Have you had any broken bones? _____ Yes _____ No If yes, please list and give dates: ______________________
   ____
8. What is your physical activity at work? _____Mostly Sitting _____Light Manual Labor _____Moderate Manual Labor _____Heavy Manual Labor
9. List any major accidents you have had other than those that might be mentioned above: ______________________
   ____
10. Do you exercise? ______ What type of sports? ______________________________
    _____None _____1-2 times week _____3-4 times week _____5-7 times week
    _____Cardiovascular _____Street _____Walking
11. To your knowledge, have you had any diseases, major accidents, or injuries not indicated on this form either in the past or the present?______Yes______No
    If yes, please explain: ____
12. What is your present level of stress?______None______Minimal _____Moderate _____Severe
13. Women Only: Are you pregnant or is there any possibility you may be pregnant?_____Yes______No_____Uncertain
14. Do you smoke?_______Yes _____No Number per day? ________
15. How much alcohol do you drink on a weekly basis? __________
16. How much caffeine beverages do you drink on a daily basis? __________
17. Do your family have a history of any of the following? _____Cancer _____Heart Disease _____Stroke _____Scoliosis _____Back Problems _____Headaches _____Other
18. Remarks: ____
    ____
    ____
19. Please place an "X" on the line below indicating your level of a problem. (Rate Severity of your Pain 1 is Mild Pain 10 is Severe)
    1 2 3 4 5 6 7 8 9 10

    [____]
    NO SYMPTOMS — EXTREME SYMPTOMS

Doctors Signature:______________________________ Date: ______________