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: _____