Confidential Patient Case History

Please fill out the **front and back**.

Name (as it appears on health insurance card)_____

Name you prefer to be called (nickname, middle name, etc)_____

Address_____ City _____ State _____

Zip Code _____ Date of Birth_____/_____/_____ Age_____

Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____ Cell Phone Carrier (Ex: Verizon) _____

E-Mail Address _____ Would you like text and email reminders? Yes/No

Marital Status M S W D # of children____ Spouse's Name_____

Person who referred you_____ Primary Care Physician_____

Have you ever received Chiropractic Care? Yes__ No__ If yes, when?_____

Do you have health insurance? Yes___ No ___ Name of Insurance Company_____

Are you covered by Medicare? Yes___ No ___

Is your condition due to an auto accident or job related injury? Yes ___ No ___

I. History

What is your major complaint? _____

Onset of pain: When it started?_____

How it started?_____

What makes it worse?_____

What makes it better?_____

Quality of pain (circle all that apply): -burning -deep -dull/ache -nagging -numb -pains/needles/tingling -sharp -shooting -stabbing -stiff -throbbing -other_____

Does the pain radiate/travel/shoot to any other body part? _____

Severity of pain-scale of 1-10 (10 being worst pain ever experienced)

1 2 3 4 5 6 7 8 9 10

When is the pain at its worst? (time of day, certain activities/positions)_____

Other doctors you have seen for this: _____

_____

Medications taken for this (what and how much):_____

_____

Other complaints: _____

II. Past Medical History

Previous significant illnesses you've had in your life (cancer, Lyme, heart, etc.)_____

_____

Previous injury or trauma (auto accident or other personal trauma):_____

_____

Medications:	**Reason for taking:**	**Dose/Frequency (if known):**
_____	_____	_____
_____	_____	_____

If you take additional medications please ask for a supplemental sheet

Prior Surgeries:

Date:	Type of Surgery:
_____	_____
_____	_____

Females:

Are you now pregnant? Yes ___ No___ Number of Previous Pregnancies_____

Do you take birth control pills? Yes___ No___ Have you reached menopause? Yes___ No___

III. Family Health History

Have any relatives had any same or similar symptoms? _____

Other health problems of relatives: Heart Disease_____ Diabetes_____ Cancer_____

Thyroid problems_____ High blood pressure/hypertension_____ Other_____

Have any relatives passed away from any of the above diseases (if yes who and from what)?

_____

IV. Social/Occupational History

Occupation:_____ Employer:_____

Recreational activities and/or hobbies:_____

Exercise routine (frequency/type of exercise):_____

Past or present military service (please specify which):_____

Do you (check all that apply): drink alcohol____ drinks per week_____ smoke marijuana____

other drugs_____ smoke cigarettes___ packs per day_____

Do you wear heel lifts or other foot supporters or orthotics? Yes ___ No ___

Age of mattress:_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. I understand and agree that health accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any reports and forms to assist me in collections from the insurance companies. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services me will be immediately due and payable.

Patient or Parent/Guardian Signature _____ Date:_____