PATIENT CASE HISTORY

Chiropractic Care Center

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: ____-_____-_____

Email Address: _____ Referred to this office by _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

____Single ____Married ___Separated ___Divorced ____Student ____Employed Occupation _____

In case of Emergency contact _____ Phone _____

Insurance Information:

Name of party responsible for payment _____ Relationship to patient _____

Health Insurance company name_____ Phone Number _____

Insurance company address _____

Group/Policy # _____ Subscriber # _____ Other _____

Secondary Insurance Information:

Name of party responsible for payment _____ Relationship to patient _____

Secondary insurance company name _____ Phone Number _____

Insurance company address _____

Group/Policy # _____ Subscriber # _____ Other _____

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

Have you seen any other providers for this condition?

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) _____

Do your symptoms affect your ability to perform daily activities such as working or driving? No Yes Somewhat

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Have you had any auto or other accidents? No Yes Describe: _____

Date of last physical examination: _____

What is your current weight? _____ lbs Height? ____ft.____in.

Do you smoke? Yes – how many per day? No - Have you ever smoked? _____

Do you drink alcohol? No Yes - how many per week? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often) _____ Please list any allergies to medications _____ Please list any other allergies _____

Please list any surgeries you have had in the last 5 years and when they were performed

_____

Please list any medications you are currently taking, along with dosage

_____

Please list any vitamins or other supplements you are currently taking

_____

Have you ever had chiropractic care? No Yes

When? _____ Why? _____ Where? _____

Were X-Rays taken? No Yes

When was your last adjustment? _____

Check any of the following problems you have or have had in the past 6 months:

Muscles & Joints
- ☐Low Back Pain
- ☐Neck Pain/Stiffness
- ☐Arm/Elbow/Wrist
- ☐Walking Problems
- ☐Difficulty Chewing
- ☐Clicking Jaw
- ☐Hip Pain
- ☐Pain in Tailbone
- ☐Pain Between Shoulders
- ☐Leg/Knee/Foot Pain

Eye, Ear, Nose & Throat
- ☐Vision Problems
- ☐Sore Throat
- ☐Earaches
- ☐Hearing Difficulty
- ☐Stuffed Nose
- ☐Ringing ears
- ☐Nose bleeds
- ☐Sinus Trouble
- ☐Swollen Glands

Nervous System
- ☐Nervousness
- ☐Numbness
- ☐Paralysis
- ☐Dizziness
- ☐Confusion
- ☐Depression
- ☐Fainting
- ☐Convulsions
- ☐Cold Extremities

General Problems
- ☐Fatigue
- ☐Night Sweats
- ☐Frequent Colds
- ☐Loss of Sleep
- ☐Fever
- ☐Headaches
- ☐Weakness

Stomach/Intestines
- ☐Poor Appetite
- ☐Excessive Appetite
- ☐Excessive Thirst
- ☐Nausea
- ☐Vomiting
- ☐Diarrhea
- ☐Hemorrhoids/Piles
- ☐Liver Trouble
- ☐Weight Trouble
- ☐Stomach Cramps
- ☐Stomach Pain
- ☐Gas/Bloating
- ☐Heartburn
- ☐Black/Bloody Stool
- ☐Colitis
- ☐Poor Digestion
- ☐Gall Bladder Problems

Kidney/Bladder
- ☐Painful Urination
- ☐Excessive Urine
- ☐Discolored Urine
- ☐Bedwetting
- ☐Bad Urine Control

Men
- ☐Prostate Pain
- ☐Impotence
- ☐Infertility

Women
- ☐Menses Irregular
- ☐Menstrual Cramps
- ☐Vaginal Pain
- ☐Breast Lumps
- ☐Pain During Sex
- ☐Infertility
- ☐Miscarriage

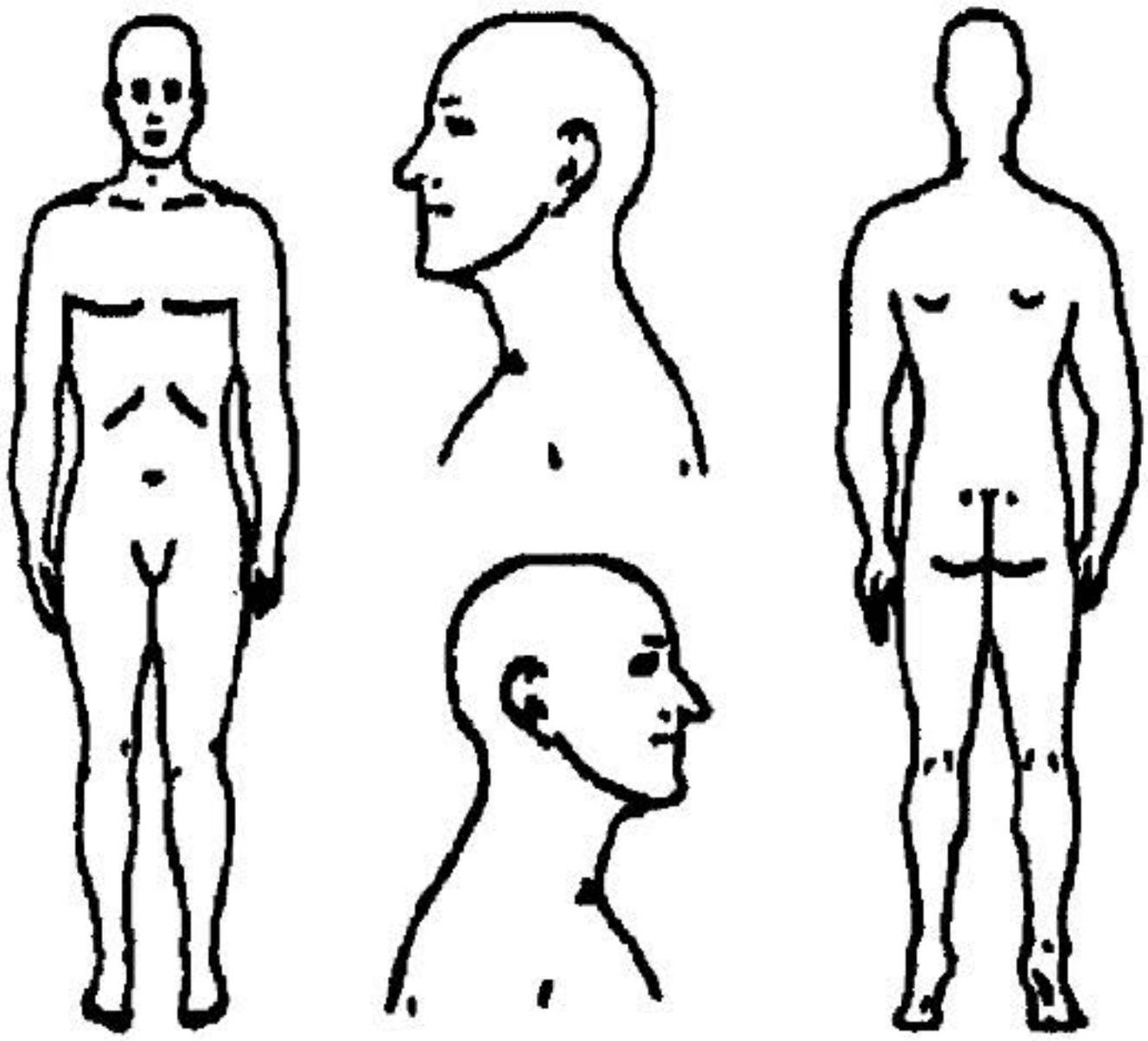
Hearts & Lungs
- ☐Wheezing
- ☐Chest Pain
- ☐Asthma
- ☐Short Breath
- ☐Low Blood Pressure
- ☐Heart Surgery
- ☐Lung Congestion
- ☐Coughing
- ☐Spitting Blood
- ☐Varicose Veins
- ☐Ankle Swelling
- ☐Bronchitis
- ☐Irregular Heart Beat
- ☐High Blood Pressure

Family History:
Family Members- present and past health conditions (ex. Heart disease, cancer, diabetes, etc):

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to this clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Additionally, I authorize the staff to perform any necessary services needed during diagnosis or treatment. I understand this statement and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my medical status.

_____	_____	_____
Patient (or responsible party) signature	Relationship to Patient	Date

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



Numbness
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Pins & Needles
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Burning
~~~~~

Aching
XXXXXX

Stabbing
••••••
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