

CONFIDENTIAL PATIENT CASE HISTORY

Date today _____

Name _____ Birth Date _____
Address _____ Home phone _____
City, State & Zip _____ Cell phone _____
Social Security # _____ Driver's License # _____
Employer _____ Occupation _____ Phone (W) _____
Sex: M _____ F _____ Marital Status: S _____ M _____ D _____ W _____
Spouse name _____ Spouse employer _____ Spouse phone (w) _____

IN CASE OF EMERGENCY: (relative or friend not living in your home.)

Name _____
Address _____ Phone _____

How did you hear about our office? _____
Have you ever seen a Chiropractor before? yes _____ no _____
If yes, Last Chiropractic Care Date _____ Doctor's Name _____
Treated for What...and the Results _____

What is your major complaint? _____

How long have you had this condition? _____
Have you had this or similar conditions in past? (when) _____
Previous diagnoses and treatments received for present condition _____
With Whom? _____

What aggravates your condition? _____
What helps your condition? _____

Is condition getting worse? Yes _____ No _____ Constant _____ Comes and Goes _____
Is condition interfering with: Work _____ Sleep _____ Daily Routine _____ Other _____

Is this a Workman's Comp. Accident? Yes _____ No _____ Is this an Auto Accident? Yes _____ No _____
* * * * *

Please enter: "2" (Had), or "3" (Have) in front of all of the following signs and symptoms. Leave blank if Never. A complete history and understanding of your health will help us facilitate your care.

GENERAL SYMPTOMS

- _____ Allergies? _____
_____ Dizziness
_____ Headache
_____ Loss of weight
_____ Vision problems, explain

MUSCLE & JOINTS

- _____ Low back pain
_____ Neck pain or stiffness
_____ Numbness/pain in extremities:
Where? _____
_____ Pain between shoulders

RESPIRATORY

- _____ Chest pain
_____ Chronic cough
_____ Difficulty breathing
_____ Wheezing
_____ Spitting blood

CARDIO-VASCULAR

- _____ High blood pressure
_____ Low blood pressure
_____ Swelling of ankles
_____ Varicose veins

GENITO-URINARY

- _____ Bed wetting
_____ Painful urination
_____ Frequent urination
_____ Inability to control bladder
_____ Prostate problems

FOR WOMEN ONLY

- Are you pregnant? Yes _____ No _____
Do you have children?
Yes _____ No _____
_____ Problems in pregnancy?
If so, what? _____

Are you presently taking any medications (prescription or patent?) If so, what? _____

List any accidents and dates: Auto _____

Sports _____ School _____

Other _____

Were you ever knocked unconscious? _____ How? _____

Have you been hospitalized? _____ Why? _____

Age of your mattress _____ Comfortable? _____ Use a bed board? _____

Do you suffer from any condition other than that for which you are consulting us? _____

FAMILY HISTORY (Many health problems are the result of hereditary weaknesses, thus information about your family members will give us a better picture of your total health.)

Name

Relation

Past & Present Problem

Cancer or Diabetes in Family? List type and whom: _____

PLEASE GIVE MOST CURRENT DATE AND RESULTS:

Height: _____ Weight: _____

Blood Test _____

Dental Exam _____

HIV Test _____

Positive _____ Negative _____

Physical Exam _____

Urine Test _____

X-ray (Types) _____

Where taken? _____

Surgeries? _____

<u>HABITS:</u>	Heavy	Mod	Light	None
Alcohol	()	()	()	()
Appetite	()	()	()	()
Coffee	()	()	()	()
Drugs	()	()	()	()
Exercise	()	()	()	()
Tobacco	()	()	()	()
Sleep	()	()	()	()

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. 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 rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

PATIENT'S SIGNATURE X _____ Date _____