

CONFIDENTIAL PATIENT CASE HISTORY

Patient: _____ Date _____
 Last First Maiden M.I.

Address: _____ Home Phone: _____
 Street

 City State Zip

Single Married Separated Divorced Widowed

Children? _____ How Many? _____ Social Security # _____ Birth Date _____

Referred by _____ Previous Chiropractor _____

Employer _____ Occupation _____

Business address _____ Business Phone _____

Name of spouse _____ Spouse's Employer _____

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home)

Name _____

Address _____ Phone _____

Is this a work-related injury? _____ Car accident? _____ Other? _____

Do you have insurance? _____ What company? _____ ID# _____

Other medical insurance _____ Subscriber: Self Spouse

ED# of 2nd insurance _____ Medicare? Yes No ID# _____

INSURANCE CLAIMS

Please be advised that we will be happy to file any insurance claims you have. We are a participating physician with Blue Million, Blue Choice, GHI, Empire Metropolitan & Preferred Care. We are not a participating physician with Medicare, but we are required to file your claim and the payment will come directly to you.

I understand that I am ultimately responsible for any balance my insurance does not cover.

Patient Signature _____

Primary Care Physician

NAME _____

DATE _____

PAST MEDICAL TREATMENTS

Drugs you now take: _____

Conditions requiring medication: _____

Supplements taken including herbal: _____

List surgical operations/hospitalizations and years: _____

Previous chiropractic care and years _____

Have you ever had a mental/emotional disorder? _____

Illnesses for which you have been treated _____

PAST HISTORY OF INJURIES

Auto accidents and years _____

Fractures and years _____

Knocked unconscious? _____

Sprains/strains? _____

Date of last visit to doctor? _____ Reason? _____

FAMILY HEALTH INFORMATION

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

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

HABITS	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

REVIEW OF SYSTEMS

What type of regular exercise do you perform?

- None Light Moderate Strenuous

For each of the conditions listed below, place a check in the Past coloum if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

- | <i>Past</i> | <i>Present</i> | | <i>Past</i> | <i>Present</i> | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Wt. Gain/Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip/Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee/Lower Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle/Foot Pain | | | |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> | Tumor |
| | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Swelling/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis |
| | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | | | |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Smoking/Use Tobacco |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |

Females Only

- Birth Control Pills
 Hormonal Replacement
 Pregnancy

Other Health Problems/Issues

HISTORY OF PRESENT ILLNESS

Name _____ Date _____

What is your chief complaint?

- | | | | |
|-------------------------------------|-----------------------------------|--------------------------------|--|
| <input type="checkbox"/> Right | <input type="checkbox"/> Left | | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip | <input type="checkbox"/> Mid back <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Arm | <input type="checkbox"/> Thigh | <input type="checkbox"/> Wrist _____ |
| <input type="checkbox"/> Upper back | <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee | <input type="checkbox"/> Leg |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Hand | <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot |

Which best describes your pain?

- | | | | |
|-----------------------------------|------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Burning | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Ache | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Gripping | <input type="checkbox"/> Other _____ | |

How frequent is your pain?

- | | |
|---------------------------------------|---------------|
| <input type="checkbox"/> Constant | (76-100%) |
| <input type="checkbox"/> Frequent | (51-75%) |
| <input type="checkbox"/> Occasional | (26-50%) |
| <input type="checkbox"/> Intermittent | (25% or less) |

Indicate the intensity of your pain at its highest (H) and lowest level (L)

0 1 2 3 4 5 6 7 8 9 10

Your symptoms are:

- | | | | |
|-------------------------------------|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Decreasing | <input type="checkbox"/> Increasing | <input type="checkbox"/> Not changing | <input type="checkbox"/> Comes and goes |
|-------------------------------------|-------------------------------------|---------------------------------------|---|

Symptoms are worse in the

- | | | | | |
|----------------------------------|------------------------------------|--------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Night | <input type="checkbox"/> Increases during day | <input type="checkbox"/> Same all day |
|----------------------------------|------------------------------------|--------------------------------|---|---------------------------------------|

When did this episode begin (specific date if possible) _____

What event caused your most recent episode _____

Have you previously been treated for this episode by another physician? Yes No

Are you currently being seen by another physician for this episode? Yes No

If yes, by whom? _____

When & what treatment _____

In the past have you been treated for the same or similar problem Yes No

If yes, who did you see _____

When and what treatment did you receive _____

PRIMARY CARE PHYSICIAN _____

Name _____

Date _____

What makes problem better?

- Nothing Lying down Walking Standing
- Sitting Movement Exercise Inactivity

What makes it worse?

- Nothing Lying down Walking Standing
- Sitting Movement Exercise Inactivity

How would you rate your general stress level...

- Little or no stress Minimal stress Moderate stress Greatly stressed

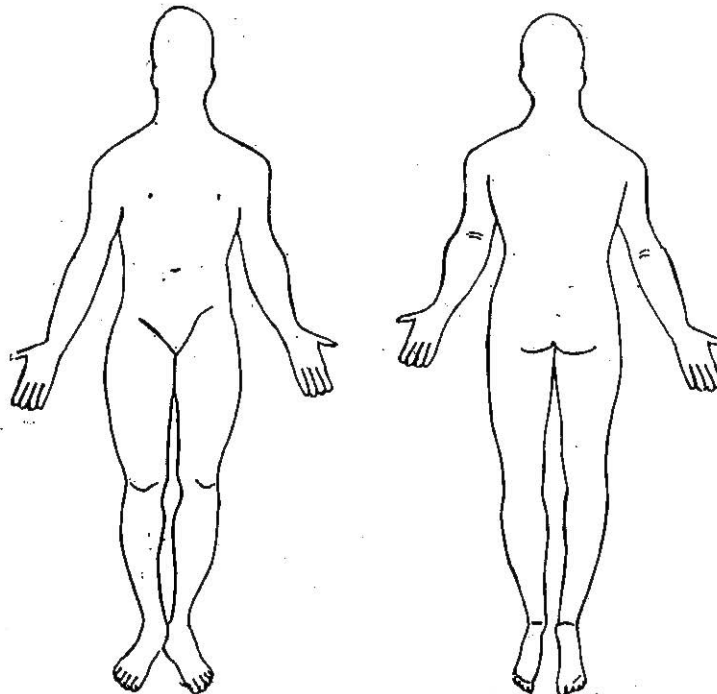
General Physical Activity:

- No regular exercise program Light exercise program Moderate exercise program
- Strenuous exercise program

Type of exercise _____

Mark the area on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

NUMBNESS — PINS & NEEDLES 0000 BURNING XXXX ACHING **** STABBING IIII



NO PAIN	0	1	2	3	4	5	6	7	8	9	10	EXTREME PAIN
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