

CONFIDENTIAL CASE HISTORY

Confidential information required for case history file

Date: _____

Name: _____ SS# _____

Daytime Phone: _____ Evening Phone: _____

Cell Phone: _____ (optional) Email: _____ (optional)

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Male: _____ Female: _____ Age: _____ Marital Status: M S W D

Occupation: _____ Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Spouse/ Responsible Party: _____

Occupation: _____ Employer: _____ Work Phone: _____

Name of Relative not living with you: _____ Telephone _____

Address: _____ City: _____ State: _____ ZIP: _____

Referred by: _____ Have you had previous chiropractic care: Yes _____ No _____

Where: _____ When: _____

Why: _____ X-Rays taken: _____

Insurance and Financial information

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

Does Medicare cover you? Yes No

Do you have health insurance? Yes No

If yes, name of company _____ policy# _____

I agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I understand that if I terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. Furthermore, I understand that if I cancel my appointment I must give 24 hour notice in order for the time slot to be filled if I do not want a charge to incur.

I have read and understand the above information:

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

MAJOR COMPLAINT

Describe your major complaints in detail: _____

Date when condition first started: _____ If known, state incident or cause of pain _____

Have you had this or similar conditions in the past? ____ What activities aggravate your condition? _____

Is this condition interfering with your: Work? Sleep? Activities of Daily living? Other? _____

Have you ever been treated for this condition? Yes No If yes, by whom? _____

How long had it been since you have really felt good? _____

Age of mattress you sleep on? _____ Comfortable? Yes No

Please list all health care providers you see:

Please list all medications and supplements you are taking:

Please list previous MAJOR car accidents, falls, and injuries. Give dates: _____

Please list any surgical procedures you have had. Give dates: _____

Major illnesses: _____

FAMILY HISTORY:

Please answer the following: **Mother** **Father** **Sisters** **Brothers** **Have:**

_____ High Blood Pressure _____ Low Blood Pressure _____ Hypoglycemia
_____ Diabetes _____ Cancer _____ Heart Disease _____ Other _____

Weight _____ Gained or Lost in the past two years _____ Last Physical Exam _____

Last Eye Exam _____ Last Dental Check-up _____ Do you wear: Heel Lifts Arch Supports

Habits: Supplements	Alcohol	Coffee	Tobacco	Rx Drugs	Exercise	Sleep	Appetite	Recreation	Sweets	Vitamin/Mineral
Heavy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Moderate	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Light	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
None	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

PATIENT SYMPTOM CHART

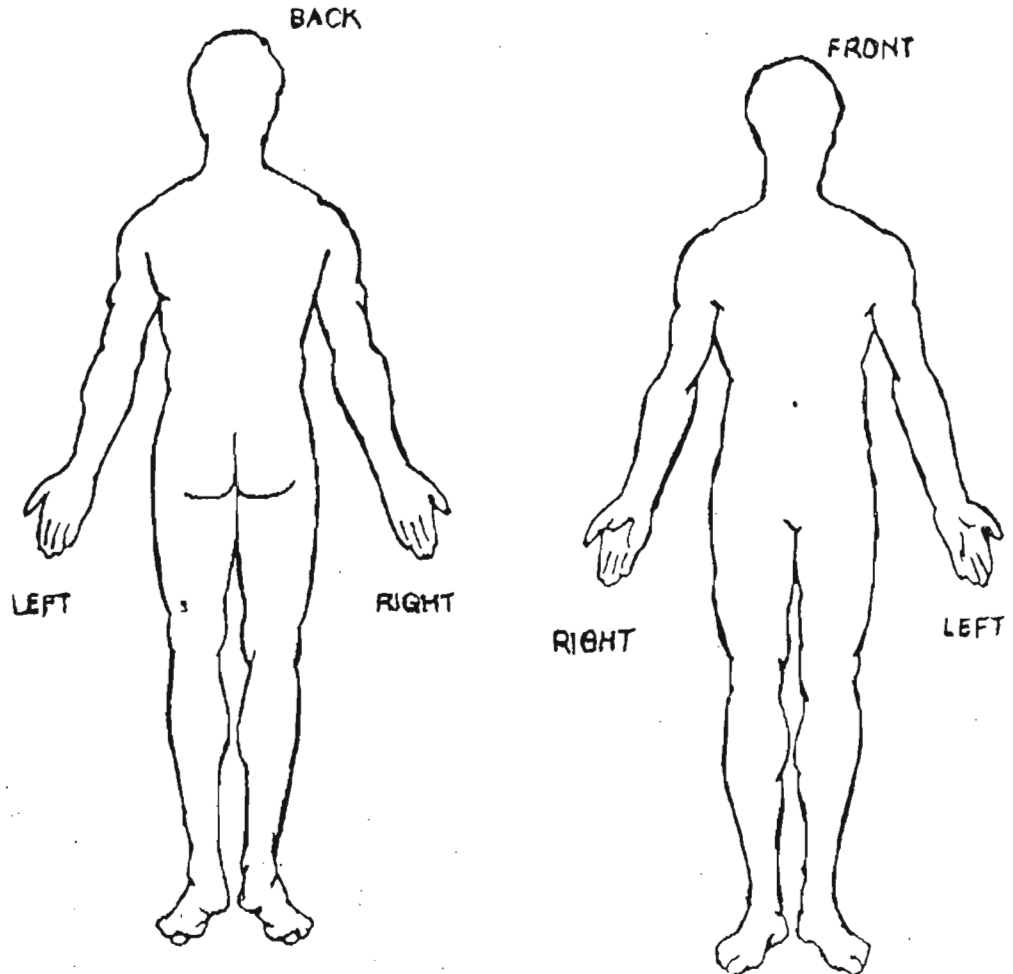
- GASTRO-INTESTINAL**
- CONSTIPATION
- DIARRHEA
- DIGESTIVE PROBLEMS
- STOMACH PAIN
- VOMITTING BLOOD
- GALL BLADDER TROUBLE
- HEMORRHOIDS
- LIVER TROUBLE
- SKIN**
- BRUISING
- BOILS
- DRYNESS
- GENITO-URINARY**
- PAINFUL INTERCOURSE
- PAINFUL URINATION
- DIFFICULTY STARTING URINE
- INABILITY TO CONTROL URINE
- BLOOD IN URINE
- BED WETTING
- KIDNEY INFECTION
- PROSTATE TROUBLE

- MUSCLES AND JOINTS**
- FOOT PROBLEMS
- SWOLLEN JOINTS
- HERNIA
- CARDIO VASCULAR**
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- PREVIOUS HEART TROUBLE
- PREVIOUS STROKE
- FOR WOMEN ONLY**
- CRAMPS ___ BACKACHE
- EXCESSIVE FLOW
- HOT FLASHES
- IRREGULAR CYCLES
- HOARSENESS
- PAINFUL MESTRUATION
- VAGINAL DISCHARGE
- RESPIRATORY**
- CHEST PAINS
- CHRONIC COUGH
- DIFFICULTY BREATHING
- FREQUENT COLDS
- PATIENT PAIN DRAWING**

- SPITTING OF BLOOD
- ALLERGIES
- EYS-EARS-NOSE
- EYE PAIN
- EAR ACHES
- RINGING IN EARS
- NASAL DISCHARGE
- NOSE BLEEDS
- SINUS TROUBLE
- DIFFICULTY SWALLOWING
- FREQUENT URINATION
- ASTHMA
- GENERAL**
- WEIGHT LOSS
- NERVOUSNESS
- EMOTIONAL PROBLEMS
- HEADACHES
- DIZZINESS
- FAINTING
- TREMORS
- OTHER
- OTHER

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

- ACHING: A
- NUMBNESS: N
- PINS AND NEEDLES: X
- BURNING: B
- STABBING: S
- OTHER: O _____



The information I have provided about my health and activities is accurate and complete.

Signature _____ Date _____