CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. Date:_____
Name: _____ Social Security #_____
Address: _____ City: _____ State: _____ Zip: _____
Home Telephone: _____ Age: _____ Birth Date: _____
Employer, Address, and Telephone: _____
Occupation and general description of physical activities involved :_____
Other activities you participate in, i.e. sports, hobbies etc: _____
Who referred you to our office: _____Have you had previous chiropractic care :_____
If so; Where: _____When: _____
What was your problem at that time: _____Were x-rays taken:_____

GENERAL HEALTH INFORMATION:

Your approximate Height:_____ Weight:_____ Is your weight fairly constant ?_____
Please check if you have ever suffered from: _____ Cancer of any type _____ Heart Disease ____ Diabetes _____ Arthritis
_____ Digestive disorders _____ Bladder or Bowel problems _____ High blood pressure, or any other vascular disease
_____ Stroke or TIA _____ Dizziness, Blurred Vision, Slurred Speech or Partial Paralysis
_____ Any adverse, or "bad" response to a chiropractic spinal adjustment in the past
Any other illness or disease: _____
Family Health History: Please list any major health problems your family has had, and their relationship to you: _____
_____
Who is your Medical Doctor:_____ Date of last physical exam: _____
Any problems found:_____
Any medications you are taking:_____
Please list any surgical procedures you have had, and the year:_____
Past history of any significant physical trauma, fractures, auto accidents, or other injuries (please describe): _____
_____

CURRENT REASON FOR CONSULTING THIS OFFICE:

What is your major complaint:_____
_____
Any other complaints:_____
_____
How long have you had this problem(s): _____
Have you seen anyone else for this condition(s), if so, who, what was done, and results:_____
_____
Is your condition getting progressively worse:_____
Have you had similar problems before? If so, when, how often, etc.:_____
Was the onset of your current condition gradual or sudden:_____
If sudden, what were you doing at the time it started:_____
Was there any trauma involved with your condition, i.e. accident, fall etc.:_____
Please describe how it feels, i.e. sharp, dull , achy, numb, burning, etc.:_____
Do you have any pain or numbness radiating into your arms or legs:_____
Is your condition constant , or does it come and go: _____
What seems to make your condition worse:_____
What seems to help:_____
On a scale of 10, with 0= to no pain and 10 = to severe pain, what would you rate the severity of your condition:_____
Is your condition causing any interference in your activities of daily living, i.e.; work, sleep , lifting, bending, driving, home care, etc. please describe:_____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? Yes _____ No _____
Do you have health insurance ? Yes _____ No _____
If so, what is the name of the company ?_____. Please give your insurance card, and some type of photo ID, to the receptionist and she will make a photocopy, so that we will have all of the necessary information in your file.
Name the policy is in, if other than yourself, and their relation to you :_____
If your insurance is an HMO or PPO, do you need to have a referral from your primary care physician ?: _____