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CASE HISTORY
CONFIDENTIAL INFORMATION FORM

Patients Name_____ Date_____

Soc Sec. #_____Home Phone ( )_____Cell Phone ( )_____

Address _____ City _____Zip Code _ _ _ _ _ State _ _

E-Mail Address_____

Age_____ Birth Date____/___/_____ Marital Status: M S W D How Many Children_____

Occupation_____Employer_____

Employer Address _____Work Phone_____

Name of Insurance Policy Holder_____ Soc Sec. # _____

Name of Insurance Company_____ Address_____

Name of Spouse_____ Occupation_____

Employer_____ Address _____

Patient's Nearest Relative_____ Address_____

Phone _____ Referred By_____

Is today's problem caused by: □ Auto Accident □ Workman's Compensation

Indicate on the drawings below where you have pain/symptoms

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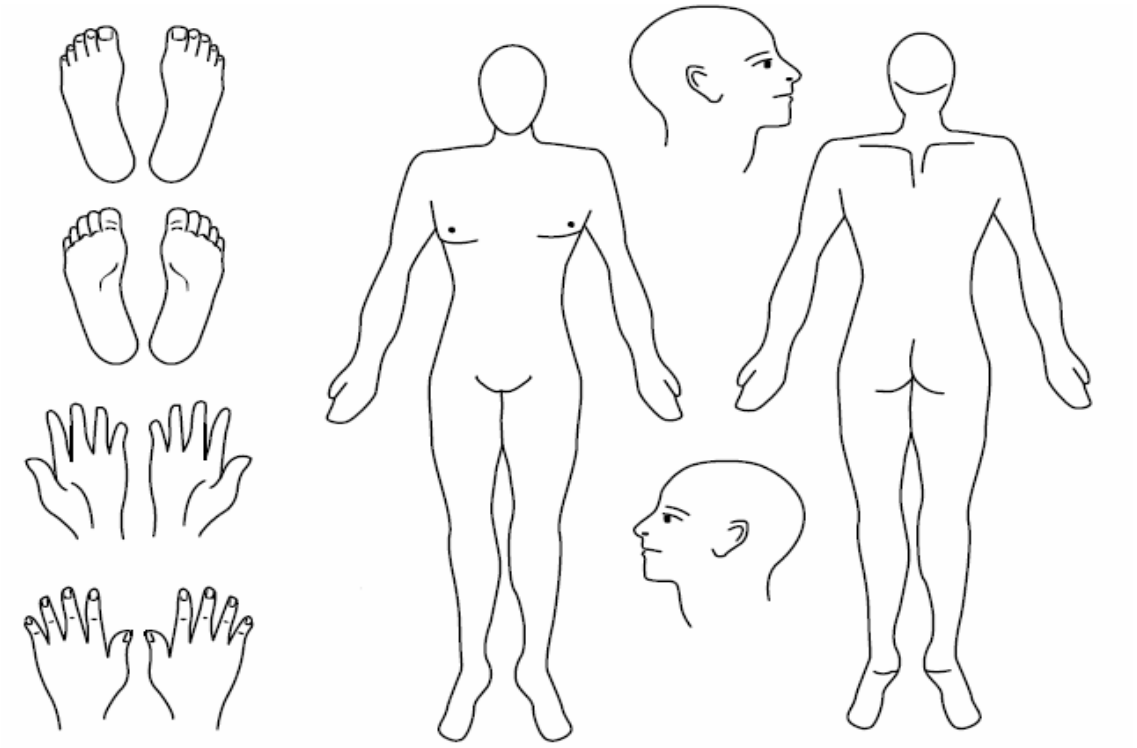

Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)_____
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*) _____
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*) _____

How often do you experience your symptoms?
- □ Constantly (76-100% of the time)
- □ Frequently (51-75% of the time)
- □ Occasionally (26-50% of the time)
- □ Intermittently (1-25% of the time)

How would you describe the type of pain?
- □ Sharp
- □ Dull
- □ Diffuse
- □ Achy
- □ Burning
- □ Shooting
- □ Stiff
- □ Numb
- □ Tingly
- □ Sharp with motion
- □ Shooting with motion
- □ Stabbing with motion
- □ Electric like with motion
- □ Other:_____

How long have you had this problem? _____ Have you ever had it before? □ No □ Yes

How do you think your problem began?

_____

What aggravates your problem?

_____

What helps the problem?

_____

How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

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How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your daily activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

Have you ever been under chiropractic care before? □ No □ Yes
if yes, where?_____

How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

_____

List any or all prescription medications you are currently taking:

_____

List any or all over-the-counter medications you are currently taking:

_____

List all surgical procedures you have had:

_____

Have you ever been hospitalized? □ No □ Yes
if yes, why?_____

Have you had significant past trauma? □ No □ Yes

_____

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

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Dizziness			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		For Females Only	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			

□	□ Cancer	□	□ General Fatigue
□	□ Tumor	□	□ Muscular Incoordination
□	□ Asthma	□	□ Visual Disturbances
□	□ Chronic Sinusitis	□	□ Abnormal Weight Gain/Loss
□	□ Other:_____		

Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis	□ Diabetes	□ Lupus
□ Heart Problems	□ Cancer	□ ALS

Anything else pertinent to your visit? _____

PAYMENT OF THE FIRST VISIT IN FULL IS REQUIRED

Person responsible for payment _____

Are you insured? □ No □ Yes Name of Insurance Company_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. 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.

Patients Signature _____Date_____

Guardian or Spouse's Signature authorizing care _____ Date_____