Required for Your Case History File: All Information Is Confidential

Full Legal Name_____ Name you prefer_____

Mailing Address_____

City_____ State_____ Zip Code_____

Telephone (Home) _____ Telephone (Work) _____

Email _____ Referred by_____

Occupation_____ Employer_____

Name of Spouse_____Number of Children_____

Emergency Contact _____Telephone_____

Age_____ Date of Birth _____ Sex _____ Years of Education_____

Circle one: Married Single Widowed Divorced Separated

Past chiropractic care? Yes ❑ No ❑ If yes, who? _____

Who is your primary care physician? _____
Date of Last Physical Examination_____

Have you been treated for any health condition by a physician in the last year? Yes ❑ No ❑

What medications/vitamins/herbs are you taking?_____
_____
_____Are you allergic to any medications? Yes ❑ No ❑

Previous serious illness/ hospitalization: (Please date & describe) _____
_____

Have ever had: Surgery Yes ❑ No ❑ Fractures Yes ❑ No ❑ Car Accidents Yes ❑ No ❑
Falls Yes ❑ No ❑ On-Job Injury Yes ❑ No ❑

Family history of: Heart disease Yes ❑ No ❑ Cancer Yes ❑ No ❑ Diabetes Yes ❑ No ❑

If you are female, are you possibly pregnant? Yes ❑ No ❑ Date of last menstrual period ____

Primary Symptom/Problem for this visit _____
_____

Have you been prescribed an opioid for your primary problem? Yes ❒ No ❒
Have you had a previous surgery for your primary problem? Yes ❒ No ❒
Are you considering surgery for your primary problem? Yes ❒ No ❒
Have you had a previous steroid injection for your primary problem? Yes ❒ No ❒
Are you considering a steroid injection for your primary problem? Yes ❒ No ❒

Date symptoms first began _____

How did your symptoms first begin? _____

Other Symptoms _____

Pains is: Constant ❑ Intermittent ❑ Is your condition getting? Worse ❑ Better ❑ Same ❑

What activities aggravate your condition?_____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day?_____

Is this condition interfering with work? Yes ❑ No ❑ sleep? Yes ❑ No ❑ routine? Yes ❑ No ❑

Other doctors seen for this condition _____

List home remedies tried _____

Do you have any of the following?

Constitutional
___ Unexplained Weight Loss
___ Fatigue or Weakness
___Fever

Eyes
___Glaucoma
___Cataracts
___Double Vision

Ears, Nose, Throat
___ Difficulty Hearing
___Buzzing or Ringing in Ears
___Dizziness
___ Loss of Smell
___Sinus Trouble
___ Difficulty Swallowing
___Loss of Taste

Skin
___Rashes
___Hives
___Itching

Allergic/Immunologic
___Hives/Hay Fever

Respiratory
___Cold/Flu/Cough
___Coughing Blood
___Wheezing

Gastrointestinal
___Nausea or Vomiting
___Constipation
___Diarrhea
___Digestive Problems

Genitourinary
___Blood in Urine
___Bladder Leakage
___Burning/Frequent Urination

Musculoskeletal
___Spinal Pain
___Joint Swelling
___Joint Stiffness

Cardiovascular
___Chest Pain
___Shortness of Breath
___Racing Heartbeat
___Fainting Spells

Neurological
___Headaches
___Memory Loss
___Tremors
___Numbness
___Loss of Strength
___Seizures

Mental Status
___Anxiety/Depression
___Mood Swings
___Difficult Sleeping
___Stress

Endocrine
___Loss of Hair
___Heat/Cold Intolerance
___Diabetes
___Excessive Sweating
___Change in Appetite

Hematologic/Lymphatic
___Ease of bruising
___Gums Bleed Easily
___Enlarged Glands

Check if you have had any of the following symptoms in the last <u>30 days</u>:

Pain worse at night ❑ Constant pain unrelated to motion ❑ Unexplained weight loss ❑
Loss of bowel or bladder control ❑ Bacterial infection ❑ Surgery ❑ Fever or chills ❑

Check if you have ever had any of the following:

History of Cancer ❑ History of HIV ❑ Use of Steroids ❑ Use of IV Drugs ❑ Blood Transfusions ❑

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information you deem appropriate to any insurance company.

Signature _____Date _____form 105 a