CASE HISTORY
CONFIDENTIAL INFORMATION FORM

Date _____

Patient Name:_____ Date of Birth _____

Home Phone ( ) _____ Cell Phone ( ) _____

Address _____ City _____ Zip Code _____ State _____

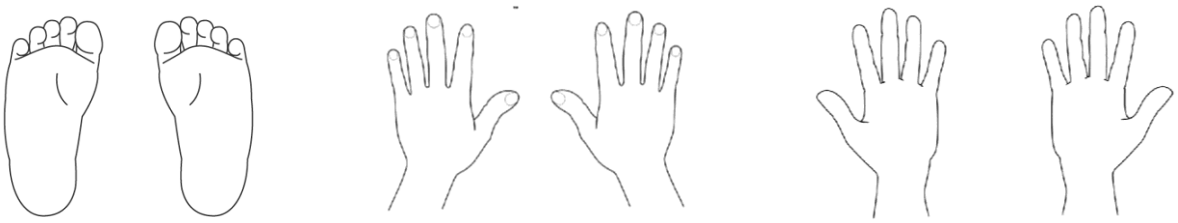
Age ____ Marital Status: M S W D E-Mail Address _____

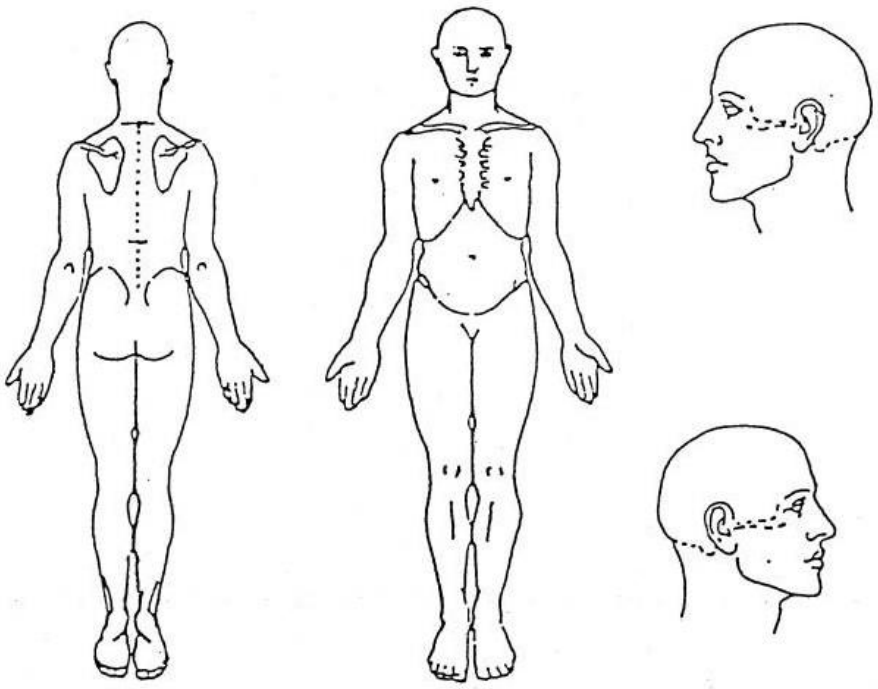
PRIMARY DOCTOR _____ Location _____

Insurance Provider _____

Is today's problem caused by Auto Accident _____ Workman's Compensation _____

Indicate on the drawings below where you have pain/symptoms.





Using a scale from 0-10 (10 being 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 (-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**

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**
- ☐ **ER Physician**
- ☐ **Massage Therapist**
- ☐ **Neurologist**
- ☐ **Orthopedist**
- ☐ **Physical Therapist**
- ☐ **Primary Care Physician**
- ☐ **Other: _____**
- ☐ **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?

- ☐ **Strenuous**
- ☐ **Moderate**
- ☐ **Light**
- ☐ **None**

List all prescription medications you are currently taking:

_____

List all of the 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? _____

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 Dependence
☐	☐ 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	☐	☐ Dermatitus/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	☐	☐ Hepatitus	☐	☐ 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** ☐ **Lupus** ☐ **Cancer**
☐ **Diabetes** ☐ **Heart Problems** ☐ **ALS**

Anything else pertinent to your visit? _____

PAYMENT OF THE FIRST VISIT IN FULL IS REQUIRED

Person responsible for payment _____

Are you insured? ☐ Yes ☐ No 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 _____

Email Release Form

Please provide your email and sign below to receive email appointment reminders, massage availabilty due to cancelations, as well as special offers and informational emails.

Email _____

Signature _____ **Date** _____