

CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION (PLEASE ANSWER EACH QUESTION. IF THE QUESTION DOES NOT APPLY IN YOUR CASE WRITE NA FOR "NOT APPLICABLE" or UN FOR "UNKNOWN")
Thank You.

DATE _____

NAME _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTHDATE _____ MARITAL STATUS: M S W D NUMBER OF CHILDREN _____

SOCIAL SECURITY NUMBER _____ MALE _____ FEMALE _____

EMPLOYER _____ ADDRESS _____

OCCUPATION _____ BUSINESS PHONE _____

SPOUSE'S NAME _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ BUSINESS PHONE _____

REASON FOR THIS APPOINTMENT: (Please list chief complaints in order of severity)

1) _____ 2) _____ 3) _____

WHO REFERRED YOU? _____

MEDICATIONS TAKEN IN THE LAST TWELVE MONTHS: _____
FOR: _____

Coffee _____ (# of cups daily) Caffeine _____ Alcohol _____ Smoker _____ (# of packs)

WHEN DID YOUR SYMPTOMS FIRST BEGIN? (The most recent flare-up) _____

HAVE YOU EVER HAD THE SAME OR SIMILAR SYMPTOMS IN THE PAST? _____

HAVE YOU BEEN UNDER CHIROPRACTIC CARE BEFORE? YES _____ NO _____ WHEN? _____

WHAT CONDITIONS WERE YOU BEING TREATED FOR? _____

NAME OF CHIROPRACTOR _____

HAVE YOU BEEN TREATED BY ANY OTHER PHYSICIANS IN THE PAST YEAR? _____

FOR WHAT CONDITION(S)? _____

HAVE YOU EVER HAD SURGERY? NO _____ YES _____ DESCRIBE _____ WHEN? _____

ACCIDENTS? (CAR, MOTORCYCLE, ETC.) _____ WHEN? _____

REGULAR EXERCISE _____ VITAMINS TAKEN REGULARLY _____

FAMILY HEALTH REPORT (please list any serious illnesses or diseases of immediate family members)

PATIENT'S SIGNATURE _____ PERSON RESPONSIBLE FOR ACCOUNT _____

If patient is a MINOR, signature of parent or guardian: _____

Name _____

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1-never had; 2-previously had; 3-presently have.

MUSCULO-SKELETAL SYSTEM

- ___ Low back problems
- ___ Pain between shoulders
- ___ Neck problems
- ___ Arm problems
- ___ Leg problems
- ___ Swollen joints
- ___ Painful joints
- ___ Stiff joints
- ___ Sore muscles
- ___ Weak muscles
- ___ Walking problems
- ___ Ruptures
- ___ Broken bones

GENITO-URINARY SYSTEM

- ___ Bladder trouble
- ___ Excessive urination
- ___ Scanty urination
- ___ Painful urination
- ___ Discolored urine

FEMALE

- ___ Vaginal discharge
- ___ Vaginal bleeding
- ___ Vaginal pain
- ___ Breast pain
- ___ Lumps on breast

Are you pregnant?

___ Yes ___ No

GASTRO-INTESTINAL SYSTEM

- ___ Poor appetite
- ___ Excessive hunger
- ___ Difficult chewing
- ___ Difficult swallowing
- ___ Excessive thirst
- ___ Nausea
- ___ Vomiting food
- ___ Vomiting blood
- ___ Abdominal pain
- ___ Diarrhea
- ___ Constipation
- ___ Black stool
- ___ Bloody stool
- ___ Hemorrhoids
- ___ Liver trouble
- ___ Gall bladder problems
- ___ Weight trouble

NERVOUS SYSTEM

- ___ Numbness
- ___ Loss of feeling
- ___ Paralysis
- ___ Dizziness
- ___ Fainting
- ___ Headaches
- ___ Muscle jerking
- ___ Convulsions
- ___ Forgetfulness
- ___ Confusion
- ___ Depression

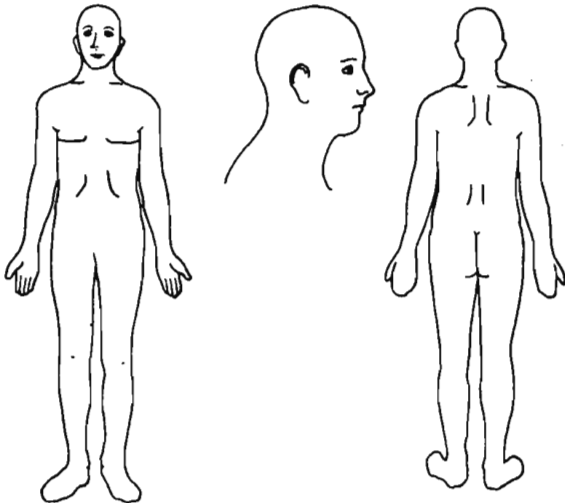
CARDIO-VASCULAR-RESPIRATORY SYSTEM

- ___ Chest pain
- ___ Pain over heart
- ___ Difficult breathing
- ___ Persistent cough
- ___ Coughing phlegm
- ___ Coughing blood
- ___ Rapid heartbeat
- ___ Blood pressure problems
- ___ Heart problems
- ___ Lung problems
- ___ Varicose veins

EYE, EAR, NOSE, AND THROAT

- ___ Eye strain
- ___ Eye inflammation
- ___ Vision problems
- ___ Ear pain
- ___ Ear noises
- ___ Hearing loss
- ___ Ear discharge
- ___ Nose pain
- ___ Nose bleeding
- ___ Nose discharge
- ___ Difficult breathing thru nose
- ___ Sore gums
- ___ Dental problems
- ___ Sore mouth
- ___ Sore throat
- ___ Hoarseness
- ___ Difficult speech
- ___ Allergies
- ___ TMJ

Please mark your areas of pain on the figures below.



CHIROPRACTIC HEALING ARTS CENTER

DO NOT WRITE BELOW THIS LINE

INSURANCE INFORMATION

IF YOU WILL BE USING YOUR INSURANCE, PLEASE COMPLETE ONLY THE SECTION PERTAINING TO THE TYPE OF CLAIM INVOLVED.

____ CHECK HERE IF YOU DO NOT HAVE INSURANCE COVERAGE (PRIVATE PAY)

A) **PRIMARY INSURANCE**

NAME OF INSURANCE CARRIER _____

ADDRESS FOR CLAIMS SUBMISSION _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED'S I. D. # _____ GROUP # _____

INSURED'S BIRTHDAY _____

B) **SECONDARY INSURANCE** (Are you covered under any othe insurance plan?) ____ NO ____ YES

NAME OF INSURANCE CARRIER _____

ADDRESS FOR CLAIMS SUBMISSION _____

INSURED'S NAME _____ RELATIONSHIP TO PATIENT _____

INSURED'S I. D. # _____ GROUP # _____

INSURED'S BIRTHDAY _____

C) **MEDICARE**

INSURED'S NAME _____ MEDICARE # _____

D) **WORKER'S COMPENSATION**

DATE OF INJURY _____ APPROX. TIME _____ a.m. p.m.

LOCATION _____

HOW DID INJURY OCCUR? (PLEASE describe exactly what you were doing and how you were hurt.) _____

WHEN WERE SYMPTOMS FIRST NOTICED? _____

DATE ACCIDENT WAS REPORTED _____

NAME OF SUPERVISOR ACCIDENT WAS REPORTED TO: _____

DID YOU CONTINUE WORKING? __ YES __ NO ARE YOU PRESENTLY WORKING? __ YES __ NO

LIST THE DATES THAT YOU WERE OFF WORK _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____ WHEN? _____

WHAT WAS DONE FOR YOU? _____

E) **LIABILITY INSURANCE** (auto accident) *Plese fill out the attached accident report*