WELCOME

CONFIDENTIAL CASE HISTORY

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)
Name ______________________________________ Date _____-_____-_____ S/S ______-_____-______ Patient No. ____________
First MI Last
Address ____ City ___________________________ State ______ Zip __________

Email address ____ Sex: Female Male Age: ____________

Birth date ___________________________ Home phone # ___________________________ Work phone # ________________

Do you prefer to receive calls at: Home Work Either

Are you: Minor Married Divorced Widowed Single Separated

Your Employer ____ Occupation ___________________________________

Business Address _______________________________________ City __________________________ State _________ Zip ________

Spouse's or parent's name ______________________________ Workplace _______________________ Work phone # ___________

Person to contact in case of emergency ____ Phone _________________________

How many children do you have _______ Their names ____

Whom may we thank for referring you to us? ____

Responsible Party

Name of person responsible for this account ____ S/S _______-______-______

Relationship to patient _______________________________ Phone # __________________________________

Address ____ City _________________________ State ________ Zip ________

Name of Employer ____ Work phone # _______________________

Reason For Today's Visit

Are you here because of an: Auto injury On the job injury If so, please fill in the following: Date of injury ________________

Insurance company___________________________ Attorney's name ________________________ Address___________________

*** IF THIS SECTION APPLIES TO YOU, PLEASE NOTIFY FRONT DESK AFTER COMPLETING THIS FORM. THANK YOU.

Current Health Condition

Reason for visit _______________________________ When did you first notice the symptoms?_______________

Is this condition getting progressively worse? _____ Is the pain constant or does it come and go? ________________

What treatment have you received for this condition? Medication Surgery Physical Therapy Other ____________________

Is this condition interfering with your: Work Sleep Daily Routine Other ____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other ____________________

Name and address of other doctor(s) who have treated you for your condition: ____

____

Have you had any X-rays, MRIs, CT Scans or other tests performed? Yes No If 'Yes', when and where? ____________________

____

Show area(s) of pain (if present) or unusual feeling

Mark the areas on this body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing	Stiffness	Cramps	Swelling
- - - - - -	OOOOOOO	xxxxxxx	*******	//////	++++++	^^^^^^^	SSSSSS
- - - - - -	OOOOOOO	xxxxxxx	*******	//////	++++++	^^^^^^^	SSSSSS

Please mark on the pain scale from zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart

Right **Left** **Left** **Right**

Head-Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:

(____)
0 **10**
no pain **severe pain**

Mid Back/Chest Pain
On a scale of zero to 10, I rate my discomfort as follows:

(____)
0 **10**
no pain **severe pain**

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:

(____)
0 **10**
no pain **severe pain**

Signature ____ Date ____________________

Daily Habits

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work, etc.)________________________

____

What vitamins do you currently take? ____

What kind of other nutritional supplements do you take (if any)? __________________________

What type of medications are you currently taking?

NAME OF DRUG	DOSES PER DAY	LENGTH OF TIME ON DRUG	FOR WHAT CONDITION

Current daily **Caffeine** intake: ____ Cups per day. Current **Alcohol** intake: _____ drinks per week. **Smoking** _____ packs per day.

Exercise: ______ X per week for _______ minutes (or ______ hours) per session. Type of exercise:______________________________

Past Health History

Please list all previous surgeries, injuries, accidents and traumas:

Month/Year	Type of Accident, surgery, trauma	Describe injury/reason for surgery

Please list all Allergies:

____

____

Have you ever had any unsuccessful pregnancies? Yes No If yes, Date ___________________

For the following list of conditions, please indicate: 1 – if you occasionally have the condition

2 – if you are experiencing the condition currently

Leave Blank if none of the above applies.

GENERAL CONDITIONS

_____ Headache
_____ Chills
_____ Fever
_____ Night Sweats
_____ Fainting
_____ Dizziness
_____ Convulsions
_____ Loss of Sleep
_____ Fatigue
_____ Nervousness
_____ Loss of Weight
_____ Numbness or Pain in arms/legs/hands
_____ Wheezing
_____ Neuralgia

GASTRO-INTESTINAL

_____ Poor Appetite
_____ Poor Digestion
_____ Excessive Hunger
_____ Belching or Gas
_____ Nausea
_____ Vomiting
_____ Vomiting Blood
_____ Pain over Stomach
_____ Constipation
_____ Diarrhea
_____ Colon Trouble
_____ Hemorrhoids (Piles)
_____ Liver Trouble
_____ Jaundice
_____ Gall Bladder Trouble

EYE EAR NOSE THROAT

_____ Poor Vision
_____ Crossed Eyes
_____ Pain in Eyes
_____ Deafness
_____ Earache
_____ Ear Noises
_____ Ear Discharges
_____ Nasal Obstruction
_____ Nose Bleeds
_____ Sore Throat
_____ Hoarseness
_____ Hay Fever
_____ Asthma
_____ Frequent Colds
_____ Enlarged Thyroid
_____ Tonsillitis
_____ Sinus Trouble

RESPIRATORY

_____ Chronic Cough
_____ Spitting Blood
_____ Spitting Phlegm
_____ Chest Pain
_____ Difficulty Breathing

GENITO-URINARY

_____ Frequent Urination
_____ Painful Urination
_____ Blood in Urine
_____ Kidney Infection
_____ Bed Wetting
_____ Inability to Control Urine
_____ Prostate Trouble

MUSCLE & JOINTS

_____ Weakness
_____ Twitching
_____ Stiff Neck
_____ Backache
_____ Swollen Joints
_____ Tremors
_____ Foot Troubles
_____ Painful Tail Bone
_____ Pain Between Shoulders
_____ Hernia
_____ Spinal Curvature
_____ Low Back Pain

CARDIO-VASCULAR

_____ Rapid Heart
_____ Slow Heart
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Pain Over Heart
_____ Previous Heart Trouble
_____ Swelling of Ankles
_____ Poor Circulation
_____ Varicose Veins
_____ Strokes

SKIN OR ALLERGIES

_____ Skin Eruptions
_____ Itching
_____ Bruising Easily
_____ Dryness
_____ Boils
_____ Sensitive Skin
_____ Hives or Allergy
_____ Eczema
_____ Allergy to Medicines
Please List:
____
____

FOR WOMEN ONLY

_____ Painful Periods
_____ Excessive Flow
_____ Irregular Cycles
_____ Hot Flashes
_____ Cramps or Backache
_____ Miscarriage
_____ Vaginal Discharge
_____ Pregnant at this Time
_____ Last PAP
OBGYN:___________________
Other: ___________________
____

Have you had any of the following diseases?

_____ Alcoholism
_____ Anemia
_____ Anorexia
_____ Appendicitis
_____ Atherosclerosis
_____ Arthritis
_____ Bulimia
_____ Cancer
_____ Chicken Pox
_____ Diabetes
_____ Diphtheria
_____ Epilepsy
_____ Emphysema
_____ Pneumonia
_____ Goiter
_____ Gout
_____ Heart Disease
_____ Influenza
_____ Lumbago
_____ Rheumatic Fever
_____ Measles
_____ Mental Disorder
_____ Multiple Sclerosis
_____ Mumps
_____ Pleurisy
_____ Polio
_____ Scarlet Fever
_____ Tuberculosis
_____ Venereal infection
_____ Whooping Cough

Why Chiropractic?
People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care   Corrective Care   Comprehensive Care   Check here if you want the Doctor to select the type of care appropriate for your condition.

________________ Date   ________________ Signature

THE PURPOSE OF GREAT LAKES CHIROPRACTIC IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN TURN EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. 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.
I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of chiropractic adjustments throughout my spine. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patients Signature ________________ **Date:** ________

Guardian or Spouse's
Signature Authorizing Care ________________ **Date:** ________

Office use only: WC Forms   NF Forms   Medicare forms 1 & 2

Form #:1000