

CONFIDENTIAL CASE HISTORY RECORD

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

E-mail Address _____ Cell Phone _____

Age _____ Date of Birth _____ Occupation _____ Sex (M) ___ (F) ___

Weight _____ Referred by _____

Employer _____ Address _____

Married ___ S ___ W ___ D ___ Children _____ Name of Spouse _____

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? _____ For what problem? _____

Were the results satisfactory? Yes ___ No ___ N/A ___ Major complaints and symptoms –

please be as specific as you can. Ask the doctor or staff for help if you need assistance in filling out this section.

How do you believe your problem (pain) began? _____

When did you first notice this problem /pain? _____

Have you lost any work? _____ Day and date you last work _____

Have you ever had this condition before or a similar condition? _____

When? _____ What positions or activities aggravate your condition? _____

_____ What position or activities relieve your condition? _____

_____ Have you been treated by a medical physician for this ailment? _____

Where? _____

Describe the type of treatment _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

Family physician's name _____

Please send a report to my family physician. Yes ___ No ___ Will this case be covered by any insurance company?

Medical ___ Auto ___ Blue Cross/Blue Shield ___ Workers' Compensation ___

Medicare ___ Other ___

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child?) _____

_____ When? _____

Are you allergic to anything you are aware of? _____

Are you presently taking any medication (aspirin included)? Yes ___ No ___ If yes, name them _____

Have you ever had any broken bones? (fractures) _____ Any dislocations? _____

What operations have you had? _____ Year _____

_____ Year _____

_____ Year _____

Have you had any cosmetic surgery, breast implants, etc? _____ Year _____

Have you had any surgery to replace hip, knee, etc.? _____ Year _____

Have you ever had cancer? Yes ___ No ___ Does your pain ever wake you from a sound sleep? Yes ___ No ___

Are you losing weight now without trying? Yes ___ No ___ Are you coughing up blood or noticing it in your

stools or urine? Yes ___ No ___ Have you had any loss of bladder or bowel control? Yes ___ No ___ Have

you lost consciousness or had double vision recently? Yes ___ No ___ Are you seeing any other doctor now for

any reason? Yes ___ No ___ Note: _____

(for women) Are you taking birth control? Yes ___ No ___ Are you pregnant? Yes ___ No ___

What was the date of onset of your last menstrual period? _____

SOCIAL HISTORY

SMOKER _____ YES or _____ NO, If Yes, How many packs _____

ALCOHOL _____ YES or _____ NO, If Yes, How much _____

Did your mother or father have any of the following:

Put an **M** for mother, **F** for father, and **B** for both

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures-Convulsions |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis-Rheumatism |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Ulcer or Stomach Problems | | |

Comments: _____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now N	Past P		Now N	Past P
Headaches _____ Frequency _____	_____	_____	Loss of Balance	_____	_____
Neck Pain	_____	_____	Fainting	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Sleeping Problems	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Diarrhea	_____	_____
Nervousness	_____	_____	Feet Cold	_____	_____
Tension	_____	_____	Hands Cold	_____	_____
Irritability	_____	_____	Arthritis	_____	_____
Chest Pains	_____	_____	Muscle Spasms	_____	_____
Dizziness	_____	_____	Frequent Colds	_____	_____
Shoulder/Neck/Arm Pain	_____	_____	Stomach Upset	_____	_____
Pins & Needles in Arms	_____	_____	Constipation	_____	_____
Pins & Needles in Legs	_____	_____	Cold Sweats	_____	_____
Numbness in Fingers	_____	_____	Fever	_____	_____
Numbness in Toes	_____	_____	Sinus Problems	_____	_____
High Blood Pressure	_____	_____	Diabetes	_____	_____
Difficulty Urinating	_____	_____	Hemorrhoids	_____	_____
Allergies	_____	_____	Leg Cramps	_____	_____
Weakness in Arms	_____	_____	Colitis	_____	_____
Weakness in Legs	_____	_____	Gall Bladder	_____	_____
Shortness of Breath	_____	_____	Indigestion	_____	_____
Fatigue	_____	_____	Belching	_____	_____
Depression	_____	_____	Vomiting	_____	_____
Lights Bother Eyes	_____	_____	Shoulder Pain	_____	_____
Loss of Memory	_____	_____	Swelling Joints	_____	_____
Ears Ring	_____	_____	Knee Pain	_____	_____
Face Flushed	_____	_____	Hay fever	_____	_____
Buzzing in Ears	_____	_____	Menstrual Difficulties	_____	_____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____

SOCIAL SECURITY NUMBER _____ DATE _____

UTICA CHIROPRACTIC CLINIC, P.C.

CASE NO. _____

Please indicate beside each activity whether you engage in it:

OFTEN = "O"

SOMETIMES = "S"

NEVER = "N"

ACTIVITY HISTORY

<input type="checkbox"/> Horseback riding	<input type="checkbox"/> Tennis	<input type="checkbox"/> Bowling
<input type="checkbox"/> Gymnastics	<input type="checkbox"/> Golf	<input type="checkbox"/> Skiing
<input type="checkbox"/> Volleyball	<input type="checkbox"/> Water Skiing	<input type="checkbox"/> Baseball/Softball
<input type="checkbox"/> Hunting	<input type="checkbox"/> Handball	<input type="checkbox"/> Fishing
<input type="checkbox"/> Racquetball	<input type="checkbox"/> Lawn mowing	<input type="checkbox"/> Walking (more than mile)
<input type="checkbox"/> Weed eater use	<input type="checkbox"/> Basketball	<input type="checkbox"/> Walking (mile or less)
<input type="checkbox"/> Snow shoveling	<input type="checkbox"/> Gardening	<input type="checkbox"/> Jogging (more than mile)
<input type="checkbox"/> Child care – Age(s) _____ Weight(s) _____		<input type="checkbox"/> Jogging (mile or less))
<input type="checkbox"/> Dancing	<input type="checkbox"/> Scuba diving	<input type="checkbox"/> Climbing stairs
<input type="checkbox"/> Back packing	<input type="checkbox"/> Aerobics	<input type="checkbox"/> Tobacco
<input type="checkbox"/> Alcohol _____ per day _____ per week	<input type="checkbox"/> Resistance training	<input type="checkbox"/> Swimming
<input type="checkbox"/> Football	<input type="checkbox"/> Free weights	<input type="checkbox"/> Exercise machines
<input type="checkbox"/> Medication _____		
<input type="checkbox"/> Other _____		

LIFESTYLE

Please indicate if any of the following is currently or has contributed to some stress or personal lifestyle changes within the past five years.

<input type="checkbox"/> Marriage	<input type="checkbox"/> Dependence problems	<input type="checkbox"/> Birth of a child
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Divorce	<input type="checkbox"/> Drugs
<input type="checkbox"/> Death of a spouse	<input type="checkbox"/> Change in job	<input type="checkbox"/> Marital separation
<input type="checkbox"/> Loss of a job	<input type="checkbox"/> Retirement	<input type="checkbox"/> Death of a family member or Friend
<input type="checkbox"/> Handicapped household member		<input type="checkbox"/> Change in living conditions
<input type="checkbox"/> Caregiver to family member		<input type="checkbox"/> Change in financial status
<input type="checkbox"/> Spousal abuse		<input type="checkbox"/> Single parent
<input type="checkbox"/> Other _____		