Silver Chiropractic & Wellness

CONFIDENTIAL PATIENT CASE HISTORY

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. *Please sign each page.*

PATIENT INFORMATION

(Underline) DR/ MR/ MRS/ MISS/ MS: TODAYS DATE:____/_____/_______

FIRST NAME:____________________ LAST NAME:____________________ MIDDLE INIT:_______

ADDRESS:________________________________CITY/STATE:_________________ZIP:___________

HOME PHONE:_______________AGE:____ BIRTH DATE:___/___/___ SOC. SEC# :____/____/_____

CELL PHONE _____________________ EMAIL ____

MARITAL STATUS: MARRIED/ SINGLE/ DIVORCE/ WIDOW (*PLEASE CIRCLE*) # OF CHILDREN: _____

OCCUPATION: ____________________EMPLOYER: ____________________WORK#: ____________

SPOUSE'S NAME: ________________SPOUSE'S EMPLOYER: ____________WORK#:____________

FAMILY PHYSICIAN: _________________ ADDRESS: ___________________ PHONE#: __________

FAMILY DENTIST: __________________ADDRESS: ___________________ PHONE: _____________

HEALTH INFORMATION*

WHAT ARE THE CHIEF COMPLAINTS FOR, WHICH YOU ARE SEEKING TREATMENT?
(*IN ORDER OF IMPORTANCE WITH 1 BEING MOST IMPORTANT*.)

1.____________________ **4.**______________________ **7.**___________________ **10.**__________________

2.____________________ **5.**______________________ **8.**___________________ **11.**__________________

3.____________________ **6.**______________________ **9.**___________________ **12.**__________________

How long have you had this condition(s)? ____________________
Have you had this condition in the past? ______________

Is this condition getting progressively worse?
YES [ ] NO [ ] CONSTANT [ ] COMES AND GOES [ ]
Is this condition interfering with your:
WORK[ ] SLEEP[ ] DAILY ROUTINE [ ] OTHER:______________________
How long has it been since you really felt good?_____________________________________
Other Doctors who treated this condition____
Date of last physical examination____
List surgical operation and years____

SIGNATURE: X________________________________Date:________________________

List any medications that have caused an allergic reaction_______________________________

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List any currently being taken: 1. _____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

Are you wearing: [ ]Sole lifts [ ]Heel lifts [ ]Inner soles [ ]Arch supports [ ]Pacemaker

Have you ever been in an auto accident? [ ]YES[ ] NO When?_____

Describe: _____

Have you had any other personal injury or accident? [ ] YES [ ] NO When?_____

Describe: _____

Are you pregnant? [ ] YES [ ] NO [ ] MAYBE

List treatments you have had for this problem and all health professionals that you are currently seeing:

PHYSICIANS **SPECIALTY** **TREATMENT & APPROX. DATES**

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

PATIENT SIGNATURE: X_____ DATE:_____

PLEASE CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOUR MEDICAL HISTORY

ALLERGIES: **ARTIFICIAL IMPLANTS:**

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[ ] Hay Fever
[ ] Food Allergies:_____
[ ] Allergic to:_____

ARTHRITIS:
[ ] Gout
[ ] Osteoarthritis: Specify Joint:_____
[ ] Rheumatoid Disease
[ ] Other:_____

ENDOCRINE DISORDERS:
[ ] Diabetes
[ ] Hypoglycemia
[ ] Parathyroid Disease
[ ] Thyroid Disease
[ ] Other:_____

EYE DISORDERS:
[ ] Glaucoma
[ ] Ocular Herpes
[ ] Other:_____

HIV DISORDERS:
[ ] Tested HIV Positive
[ ] Aids
[ ] Other:_____

KIDNEY/URINARY DISORDERS:
[ ] Bladder Infections
[ ] Blood in urine
[ ] Kidney Disease
[ ] Sugar in Urine
[ ] Other:_____

MUSCLE DISORDERS:
[ ] Muscular Dystrophy
[ ] Muscle Shaking (tremors)
[ ] Muscle Spasms or Cramps
[ ] Other:_____

NERVE DISORDERS:
[ ] Cerebral Palsy
[ ] Epilepsy
[ ] Neuralgia
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Stroke
[ ] Other:_____

[ ] Heart pace maker
[ ] Heart Valve
[ ] Joint replacement: specify joint & side:_____
[ ] Other:_____

BLOOD DISORDERS:
[ ] Anemia
[ ] Bleeding Easily
[ ] Hemophilia
[ ] Leukemia
[ ] Sickle Cell Anemia
[ ] Other:_____

HEART/CIRCULATORY DISORDERS:
[ ] Arteriosclerosis
[ ] Congenital Heart Disorders (at birth)
[ ] Coronary Artery Disease
[ ] Heart Murmur
[ ] Heart Palpitations
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Poor Circulation
[ ] Rheumatic Fever
[ ] Other:_____

LIVER DISEASE:
[ ] Cirrhosis of the Liver
[ ] Hepatitis A (infectious)
[ ] Hepatitis B (serum)
[ ] Other:_____

LUNG/RESPIRATORY DISORDERS:
[ ] Asthma
[ ] Chronic Colds
[ ] Emphysema
[ ] Frequent Cough
[ ] Lung Cancer
[ ] Shortness of Breath
[ ] Tuberculosis
[ ] Other:_____

STOMACH/INTESTINAL DISORDER:
[ ] Bloating
[ ] Colitis
[ ] Constipation
[ ] Frequent Diarrhea
[ ] Frequent Gas
[ ] Gallbladder Problems
[ ] Heartburn
[ ] Ulcers [ ] Other:_____

SIGNATURE: X _____ **DATE:**_____

ACCIDENT INFORMATION**********

If you were involved in an accident or a traumatic incident, complete this section.

Date Time of Accident: _____

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What makes your pain worse? _____

When did your condition first occur?_____

What do you believe is the cause of your pain or condition?
[ ] A motor vehicle accident (Date:_____)
[ ] A motorcycle accident (Date:_____)
[ ] A work related accident (Date:_____)
[ ] A play ground accident (Date:_____)
[ ] Athletic endeavor [ ] Fight [ ] Fall (Date:_____)
[ ] Unknown (Date:_____)
[ ] Other:_____

WHAT OTHER INFORMATION IS IMPORTANT TO YOUR CONDITION?

_____

_____

_____

_____

Briefly describe the accident: _____

_____

_____

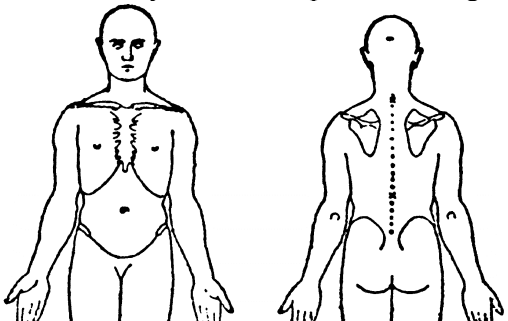
_____

DESTINATION AFTER ACCIDENT / INJURY

When did you go to the hospital? _____
Hospital Name: _____
Who drove you the Hospital?_____ Were you admitted:_____
Date Discharged: _____ Were X-rays taken? _____
Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident? _____
_____

SIGNATURE: X_____ DATE: _____

Please mark your areas of pain on the figures below.



Have you ever suffered from:
[ ] Dizziness_____
[ ] Backaches_____

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[ ] Heart Trouble_____
[ ] Diabetes_____
[ ] Arthritis_____
[ ] Headaches_____
[ ] Asthma_____
[ ] Neuritis_____
[ ] Digestive Disorders_____
[ ] Nervousness_____
[ ] Sinus Trouble_____
[ ] Neck Pain_____
[ ] Other:_____

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FAMILY HEALTH INFORMATION
(Many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health picture.)

Father:_____

_____

Mother: _____

_____

Sister: _____

_____

Brother: _____

_____

Other: _____

_____

PLEASE THINK…Is there anything else the doctor should know about you? _____

_____

_____

SIGNATURE: X_____ **DATE:** _____

INSURANCE INFORMATION:********

Health Insurance:_____
Subscriber
Name / Number:_____ Group #_____

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Secondary Health Insurance: _____
Subscriber
Name / Number:_____Group#_____

Automobile
Insurance:_____
Date & Time of Accident:_____Name of the insured: _____
Policy #:_____ Claim #:_____
Name of Adjuster:_____

If you do not have your own insurance, do you live with anybody who does?_____
Name of the Insured:_____ How are you related?_____
Policy #:_____ Claim #:_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Silver Chiropractic & Wellness 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 *Silver Chiropractic & Wellness will* be credited to my account on receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

PATIENT SIGNATURE: X_____

GUARDIAN or SPOUSE'S SIGNATURE: X_____