Clarksville Spine & Rehabilitation, LLC 815 Eastern Blvd Clarksville, IN 47129 (812) 282-7500 office (812) 282-4552 fax

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily we will not accept you as a patient. Thank You.

Full Name: _____ Called: _____ DOB: _____ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

SSN#: _____ Marital Status: S M W D Sep Spouses name: _____

Your Employer: _____ Your Occupation: _____

Employer address: _____ City: _____ State: _____ Zip: _____

Policy Holders Name: _____ Insurance holders SSN: _____ Holders DOB: _____

Holders address: _____ Holders relationship to patient: _____

Referred By: _____ **E-mail:** _____

History of Present Injury/Illness: Please list below the complaint(s) you have in order of importance, also the length of time you had these complaint(s).

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____

Is your condition related to an accident? ☐ Yes ☐ No If yes describe: _____

Ever had a similar episode before? ☐ Yes ☐ No Describe your condition: ☐ getting worse ☐ the same ☐ getting better ☐ constant ☐ comes + goes

What activities aggravate your condition? _____ What makes your condition better? _____

Have you seen any other health care provider for your present condition? ☐ Yes ☐ No Who? _____

List previous diagnoses and treatments you have received for your present condition? _____

Who is your primary care physician: _____ Phone #: _____

List all medications you presently take: _____

Past History: List any surgeries you have had

1. _____ Date: _____ 3. _____ Date: _____
2. _____ Date: _____ 4. _____ Date: _____

Have you ever been involved in a motor vehicle accident? ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe: _____

Have you ever:	Yes	No	Describe Briefly:
Been knocked unconscious?	☐	☐	
Used a crutch, cane, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fracture or broken bone?	☐	☐	
Hospitalized other than surgery?	☐	☐	
Do you:			
Now take vitamins, minerals, or herbs?	☐	☐	
Think you may need supplements?	☐	☐	
Have an allergy to any drug?	☐	☐	

Habits:	Heavy	Moderate	Light	None	Comments:
Alcohol	☐	☐	☐	☐	
Coffee	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	
Drugs	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	

In case of an emergency who should we contact?

Name: _____ Relationship: _____

Address: _____ Phone #: _____

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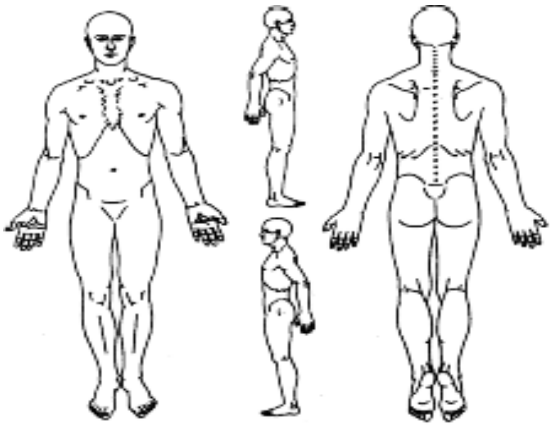
Please check the appropriate box for any of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. This is a confidential health report.



On the drawing to the right, circle the area(s) where you have pain.
Then, *for each area that you have circled*, designate a number from *0 to 10* (**with 10 being the most pain**) that corresponds to your pain level at its ***worst***.

0-10	Burning	Sharp	Numb	Tingling	Ache	Other
___ Headache	☐	☐	☐	☐	☐	☐
___ Neck	☐	☐	☐	☐	☐	☐
___ Shoulder	☐	☐	☐	☐	☐	☐
___ Mid Back	☐	☐	☐	☐	☐	☐
___ Elbow	☐	☐	☐	☐	☐	☐
___ Wrist	☐	☐	☐	☐	☐	☐
___ Low back	☐	☐	☐	☐	☐	☐
___ Hip	☐	☐	☐	☐	☐	☐
___ Knee	☐	☐	☐	☐	☐	☐
___ Ankle	☐	☐	☐	☐	☐	☐
___ Foot	☐	☐	☐	☐	☐	☐
___ Other _____	☐	☐	☐	☐	☐	☐

P – Previous C – Current

P	C	
		General
☐	☐	Allergy / Hay fever
☐	☐	Convulsions / Tremors
☐	☐	Dizziness
☐	☐	Depression / Anxiety
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Insomnia
☐	☐	Loss of Weight
☐	☐	Night Sweats
		Muscle & Joint
☐	☐	Arthritis
☐	☐	Bursitis / Swollen Joints
☐	☐	Night Pain
☐	☐	Muscle cramps at night
☐	☐	Muscle weakness
☐	☐	Scoliosis
☐	☐	Stiffness
☐	☐	Surgical implant

P	C	
		Gastro-Intestinal
☐	☐	Belching or gas
☐	☐	Bloating after meals
☐	☐	Constipation / Diarrhea
☐	☐	Gall bladder removed
☐	☐	Colitis
		EENT
☐	☐	Deviated septum
☐	☐	Frequent colds / ear infections
☐	☐	Nosebleeds
☐	☐	Tinnitis
		Endocrine
☐	☐	Afternoon headaches
☐	☐	Crave salt
☐	☐	Coarse or thinning hair
☐	☐	Get "shaky" if hungry
☐	☐	Inability to concentrate
☐	☐	Increase in weight
☐	☐	Sensitive to cold
		Skin
☐	☐	Bruise easily
☐	☐	Hives / rash

P	C	
		Cardio-Vascular
☐	☐	Asthma
☐	☐	Chest Pain
☐	☐	Chronic cough
☐	☐	Difficulty breathing / Wheezing
☐	☐	Hardening of arteries
☐	☐	High / Low blood pressure
☐	☐	Pain over heart / chest pain
☐	☐	Spitting up blood / phl egm
☐	☐	Swelling of ankles
		Genito-urinary
☐	☐	Bed-wetting
☐	☐	Unable to control kidneys
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Prostate trouble
		For Women Only
☐	☐	Hot flashes
☐	☐	Irregular / Painful / Excessive menses
☐	☐	Painful breasts
☐	☐	Premenstrual tension

☐ Yes ☐ No Are you pregnant?

Family History: Check the following condition that applies for you, mother, and father

	You	Father	Mother	explain
☐ Cancer	☐	☐	☐	☐ _____
☐ Diabetes	☐	☐	☐	☐ _____
☐ Heart disease	☐	☐	☐	☐ _____
☐ HIV/AIDS	☐	☐	☐	☐ _____
☐ Multiple sclerosis	☐	☐	☐	☐ _____
☐ Pace maker	☐	☐	☐	☐ _____
☐ Rheumatoid arthritis	☐	☐	☐	☐ _____
☐ Stroke	☐	☐	☐	☐ _____

- I have read the Informed Consent to Treatment for chiropractic and acupuncture and I have freely decided to undergo the recommended treatment.
- I allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I've been informed and understand my rights concerning HIPPA Notice of Privacy Practices, and Use and Disclosure of Protected Health Information. (Once information is disclosed, it may not be protected by law.)
- X-rays taken at Clarksville Spine and Rehabilitation (CSR) will remain the property of CSR. Copies available for additional fee within 1 week.
- I give this office authorization to use my name for any in-office publications.
- Authorization may be denied or retracted at any time by notifying the office manager.
- I authorize payment of medical benefits to this office.

Patient signature: _____ Date: _____

Guardian's signature: _____ Date: _____

(Authorization expires 3 years from above date)