CONFIDENTIAL PATIENT CASE HISTORY

SCHOOLEY'S MOUNTAIN CHIROPRACTIC CENTER

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you, and if so how long your expected recovery may take. If we do not sincerely believe that your condition will respond satisfactorily we will not accept your case, and will attempt to make an appropriate referral for you. **THANK YOU** for your consideration and time in filling out this paperwork.

Today's Date _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) ____-_____ Work Telephone (____) ____-_____

If from out of town please provide local address and telephone number.

Address _____ City _____ State _____ Zip _____

Telephone Number (____) ____-_____

Age _____ Birth Date ____/____/____ Marital Status S M W D How many children _____

Occupation _____ Employer _____

Work Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Office Telephone (____) ____-_____

Nearest Relative & Telephone Number _____ (____) ____-_____

Who referred you to our office? _____

HEALTH INFORMATION

What is Your Major Complaint? _____

_____

Other complaints: _____

How long have you had this condition?

❑ Greater than 8 days ❑ Less than 6 weeks ❑ Greater than 6 weeks ❑ Greater than 16 weeks

Have you had this or a similar condition in the past? _____ How many episodes? ❑ less than 3 ❑ greater than 3

Describe the severity of your condition ❑ mild ❑ moderate ❑ severe ❑ crippling ❑ bedridden

To the best of your knowledge is this injury superimposed on any pre-existing structural or skeletal anomaly that you know of? _____

Is your present condition ❑ Getting better ❑ Getting worse ❑ Staying the same ❑ Coming and going

What activities aggravate your condition? _____

What provides you relief for this condition? _____

Please circle current conditions ---check former conditions

GENERAL SYMPTOMS
- ❑ Headache
- ❑ Fever
- ❑ Chills
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Gain/Loss of Weight
- ❑ Numbness/pain in arms, hands, legs, feet
- ❑ Allergy
- ❑ Wheezing
- ❑ Neuralgia/neuritis
- ❑ Depression

E.E.N.T.
- ❑ Failing vision
- ❑ Near sightedness
- ❑ Far sightedness
- ❑ Crossed eyes
- ❑ Eye pain
- ❑ Deafness
- ❑ Earache
- ❑ Ear discharge
- ❑ Nose bleeds
- ❑ Nasal obstruction
- ❑ Hoarseness
- ❑ Hay fever

E.E.N.T. continued
- ❑ Tinnitus
- ❑ Asthma
- ❑ Gum trouble
- ❑ Frequent colds
- ❑ Enlarged thyroid
- ❑ Tonsillitis
- ❑ Sinus infection
- ❑ Nasal drainage
- ❑ Enlarged glands

SKIN
- ❑ Skin eruptions
- ❑ Itching
- ❑ Bruise easily
- ❑ Dryness
- ❑ Boils
- ❑ Varicose veins
- ❑ Sensitive skin
- ❑ Hive or allergy

RESPIRATORY
- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Difficulty breathing

CARDIO VASCULAR
- ❑ Rapid beating heart
- ❑ High blood pressure
- ❑ Low blood pressure

CARDIOVASCULAR continued
- ❑ Pain over heart
- ❑ Previous heart attack
- ❑ Hardening of the arteries
- ❑ Swelling of the ankles
- ❑ Poor circulation
- ❑ Paralytic stroke
- ❑ Aneurysm

MUSCLE & JOINT
- ❑ Stiff neck
- ❑ Backache
- ❑ Swollen joints
- ❑ Painful tailbone
- ❑ Foot trouble
- ❑ Pain in shoulders
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture
- ❑ Arthritis

GENITOURINARY
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Bed wetting
- ❑ Inability to control urine

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Difficult digestion
- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting of blood
- ❑ Pain over stomach
- ❑ Constipation
- ❑ Colon trouble
- ❑ Hemorrhoids (piles)
- ❑ Intestinal worms
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Jaundice
- ❑ Colitis

FOR WOMEN ONLY
- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps or backache
- ❑ Previous miscarriage
- ❑ Vaginal discharge
- ❑ Congested breast
- ❑ Lumps in breast
- ❑ Menopausal symptoms
- ❑ Pregnancy

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?
- ❑ Appendicitis
- ❑ Scarlet fever
- ❑ Diphtheria
- ❑ Typhoid fever
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Polio
- ❑ Malaria
- ❑ Tuberculosis
- ❑ Whooping cough
- ❑ Anemia
- ❑ Measles
- ❑ Mumps
- ❑ Small pox
- ❑ Chicken pox
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart disease
- ❑ Goiter
- ❑ Influenza
- ❑ Pleurisy
- ❑ Alcoholism
- ❑ Venereal infection
- ❑ Epilepsy
- ❑ Mental disorder
- ❑ Eczema
- ❑ Drug dependency
- ❑ Emphysema
- ❑ Asthma

X-RAY CONFIRMATION: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signed: _____

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic as deemed necessary to my child.

Signed: _____ (Parent / Legal Guardian)

List your primary care doctor or any other doctors that you have consulted or sought treatment with for this condition:

Name _____ Specialty _____

Address _____ Telephone number _____

Name _____ Specialty _____

Address _____ Telephone number _____

PAST HEALTH HISTORY

What surgeries have you had and/or fractures (broken bones), etc.
Type/When/Doctor/Remarks _____

_____

Have you been in an auto accident? _____ ❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never
Describe: What/When/Symptoms/Treatment/Results _____

_____

Have you had any other serious accidents injuries and/or falls(work, personal injury, home, sports, leisure, other)? _____
❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never
Describe: What/When/ Symptoms/Treatment/Results _____

_____

OCCUPATIONAL (Please circle all appropriate answers)

Type of work station: Seated / Standing Workbench / Desk Counter / Other

Job involves – Lifting (how much : Light Medium Heavy) Bending / Stooping / Twisting / Turning / Carrying /Walking / Standing / Other

Type of chair – Executive / Steno / Bench / Stool / Folding / Other _____

Shoe style – High heels / Dress shoes / Work boots / Sneakers / Loafers / Other _____

Do any of your work activities aggravate your present main complaint? (Describe) _____

DO YOU HAVE A PERMANENT IMPAIRMENT / DISABILITY RATING? _____

Location _____ Date received _____ Rating Percentage _____

COMMENTS: _____

LEISURE
Sedentary activities – TV/Reading/Card games/Sewing/Computer/Other (circle all applicable & describe how long)

_____

Strenuous activities – Sports/exercise (type, frequency, length of time) Have you had to discontinue any activities? _____

Describe _____

How would you describe your general stress level? ❑None ❑Minimal ❑Moderate ❑High ❑Greatly Stressed

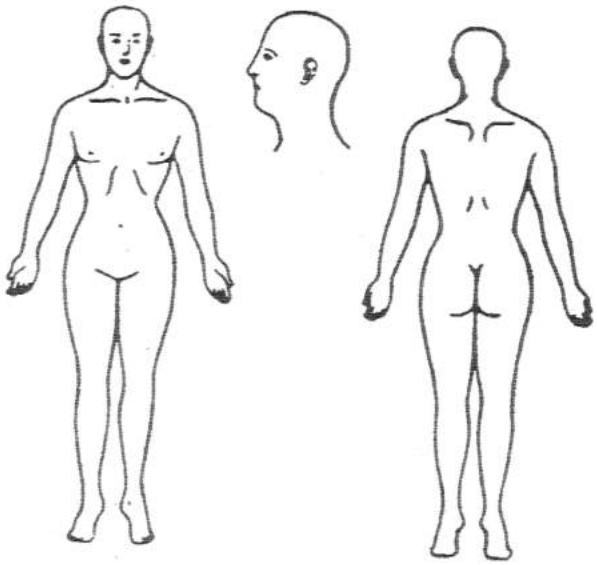
Physical activity at work ❑sedentary greater than 50% of day ❑sedentary less than 50% of day
❑light manual labor ❑manual labor ❑heavy labor

General physical activity ❑ no regular program ❑ light exercise ❑ medium exercise ❑ heavy exercise Program

Coffee, tea, caffeinated soft drinks (cups per day) _____ Tobacco (packs per day) _____

Date of your last physical examination _____

Please mark and grade your areas of pain on the figures and scale below



Extreme 10
*
*
*
*
5
*
*
*
*
Absent 0

INSURANCE INFORMATION

Is your condition due to an automobile accident or a job related injury? ❑ Yes ❑ No

If this is a work related injury do you have authorization to treat in this office? ❑ Yes ❑ No

If this is an automobile accident related have you reported this to your insurance carrier? ❑ Yes ❑ No

Do you have health insurance? ❑ Yes ❑ No If yes,

Name of Company _____ Policy #_____ Effective date____/____/____.

Are you covered by Medicare? ❑ Yes ❑ No If yes, Health Insurance # _____

Name of Company providing your medicare coverage _____ Effective date ____/____/____.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. In this age of managed care I acknowledge that verification that coverage does exist does not guarantee that payment will be made. Furthermore I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in full of all charges.

I consent to examination and treatment by the doctors of this office. And I acknowledge my responsibility for payment of all charges, even those that my insurance carrier (PPO, POS, or HMO) may not deem medically necessary but that this Chiropractic Office in the best interest of the patient does. (i.e. Examinations, Radiographic Evaluation, Chiropractic Spinal Adjustments, Adjunctive Therapy or Other Services)

I also understand that if I suspend care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by: ❑ Cash ❑ Check ❑ Credit Card

❑ Visa ❑ Mastercard ❑ Discover Card Card # _____ Exp. Date ____/____/____

All accounts not paid within 90 days will be charged 1.5% on the outstanding balanced and automatically put through on your credit card.

Patient's Signature _____ Date ____/____/____

Guardian or Spouse's Signature _____ Soc. Sec.# _____

Doctor's Signature _____ Date ____/____/____

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

Name	Relation	Past and Present Health Problems

There are two type of care: **Relief Care** which will temporarily ease your symptoms or **Corrective care** that will solve the problem.

At this time I prefer ❑ Relief Care ❑ Corrective Care Patient's Initials _____