Confidential Patient Case History

201 Broadway Cambridge MA 02139

Dear Patient: This information is considered confidential. We need this information to help determine how chiropractic may help you, as well as filling out the necessary insurance forms. Please take the time to complete this form as accurately as possible. Thank you.

Name _____ Sex _____ Today's Date _____/_____/_____

Address _____ Home Tel (____) _____ Work Tel (____) _____

City, Zip _____ Soc. Sec _____-____-_____ Birth date _____/____/____

Employer_____Occupation _____

Marital Status _____ Email address_____

Referred by:

yellow pages _____ live/work nearby _____ friend (please name) _____
health fair _____ other health care professional (please name) _____

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1) Please describe the nature and location of your pain. Be specific: _____
_____
_____

2) Indicate on this line, the level of pain you are now experiencing:

No Pain |----------|----------|----------|----------|----------|----------|----------|----------|----------|----------| **Maximum Pain**
0 1 2 3 4 5 6 7 8 9 10

3) Is the condition the result of an accident, sports injury, work postures etc.? Please describe:
_____
_____

4) How long have you had this condition? _____
5) What aggravates this condition? _____
6) Is this condition getting progressively worse? yes ___ no ___ stays constant ___ comes and goes __
7) Did you miss any time at work because of this injury? yes___ no ___
When _____

8) Have you been seen by any other doctors or chiropractors for this condition? Yes ____ No ____
If so, please fill out below
a) Name and address of doctor(s): _____
b) Dates seen: _____
c) Were x-rays taken? _____ What treatment was provided? _____

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9) Please list the name and address of you personal physician: _____
_____

10) Describe any regular exercise routine (duration and frequency): _____
_____

11) Please list any illness you have, and corresponding treatment if any: _____
_____

12) Do you take any prescribed medication? Yes _____ No _____ Name: _____

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Pneumonia	Mumps	Influenza	**Intake:**
Rheumatic Fever	Smallpox	Pleurisy	Coffee
Polio	Chicken Pox	Arthritis	Tea
Tuberculosis	Diabetes	Epilepsy	Alcohol
Whooping Cough	Cancer	Mental Disorders	Cigarettes
Anemia	Heart Disease	Lumbago	White Sugar
Measles	Thyroid	Eczema	

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL----------

Low Back Pain	Arm Pain	Walking Problems
Pain Between Shoulders	Joint Pain/Stiffness	Difficulty Chewing/Clicking Jaw
Neck Pain	General Stiffness	

NERVOUS SYSTEM----------

Nervous	Dizziness	Fainting
Numbness	Forgetfulness	Convulsions
Paralysis	Confusion/Depression	Cold/Tingling Extremities
Stress		

GENERAL----------

Fatigue	Fever
Allergies	Headaches
Loss of Sleep	

GASTROINTESTINAL----------

Poor/Excessive Appetite	Constipation	Weight Trouble
Excessive Thirst	Hemorrhoids	Gall Bladder Problems
Frequent Nausea	Liver Problems	Abdominal Cramps
Vomiting	Diarrhea	Gas/Bloating After Meals
Heartburn	Black/Bloody Stools	Colitis

GENITO-RINARY----------

Bladder Trouble
Painful/Excessive Urination
Discolored Urine

C-V-R- CODE----------

Chest Pain
Short Breath
Blood Pressure Problems
Irregular Heartbeat
Heart Problems
Lung Problems/Congestion
Varicose Veins
Ankle Swelling
Stroke

EENT CODE----------

Vision Problems
Dental Problems
Sore Throat
Earaches
Hearing Difficult
Stuffed Nose

FEMALES ONLY----------

When was your last period?

_____

Are you pregnant?

Yes No

MALES/FEMALE CODE----------

Menstrual Irregularity
Menstrual Cramps
Vaginal Pain/Lumps
Breast Pain/Lumps
Prostate Sexual Dysfunction

OTHER PROBLEMS----------

_____
_____
_____
_____

FAMILY HISTORY----------

The following members have the same
Or similar problem(s) as I do:

Mother
Father
Brother
Sister
Spouse
Child

Insurance Information:

Are you covered by health insurance? Yes _____ No _____

Name of insured _____ Relationship of insured _____

Name of Insurance Company: _____

Policy # _____ Group # _____

Amount of patient co-payment per office visit _____

--or—

Percentage covered by health insurance _____

Have you met your deductible this year? Yes _____ No _____ Deductible amount _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and form to assist me in making collection from the insurance companies. However, I clearly understand and agree that all services rendered to me are charged to me and that ultimately, I am personally responsible for payment.

Patient signature _____ Date _____

Patient Name: _____ Date _____

1) Indicate with a **mark** on this line, the level of pain you are now experiencing:

No Pain |----------| **Maximum Pain**
0 1 2 3 4 5 6 7 8 9 10

2) Listed below are **5 types** of pain. **Select the type** (or types) of pain that you are experiencing.
3) Mark the body figures (**draw below**) to indicate where on you body the pain is being felt.
Be sure to **use** the corresponding **symbols** for each type of pain.
4) Please **draw your face** on the figure below.

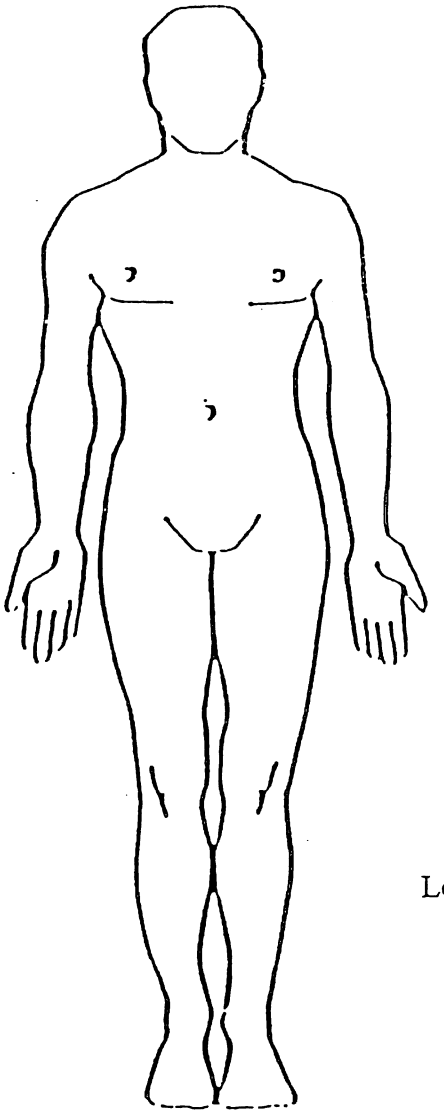
Numbness XXXXX XXXXXXXXX XXXXX

Stabbing SSSSS SSSSSSSSS SSSSS

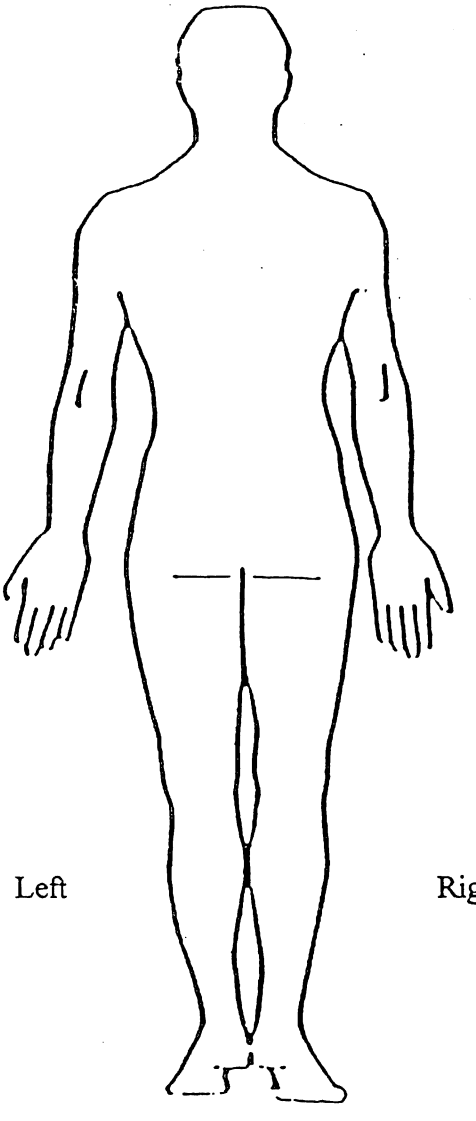
Ache ////////// ////////////////// //////////

Pins and Needles OOOOO OOOOOOOOOO OOOOO

Burning +++++ ++++++++++ +++++



Right Left



Left Right