Confidential Patient Case History

APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions.
If you need help please ask the receptionist. **PLEASE PRINT**.

Today's Date _____

Name (inc. middle name) _____ E-Mail Address_____

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Your Employer _____ Occupation _____ Years On Job _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Your Social Security # _____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Do you have a list of your prescriptions? Yes ____ No ____ Are you a Veteran? Yes ____ No ____

Spouse / Parent _____ Their Phone Number_____ Their Birthdate _____

If patient is a minor, name of legal guardian_____ Phone #_____

Referred to our office by:_____

A. CHIEF COMPLAINT: What is (are) your major complaint(s)? Are there any activities that aggravate or alleviate the pain (when standing, when sitting, etc.)?

_____

_____

B. Description of Symptoms

- ☐ Sharp Pain
- ☐ Shooting
- ☐ Stabbing
- ☐ Burning
- ☐ Radiating
- ☐ Tingling
- ☐ Numbness
- ☐ Throbbing
- ☐ Dull Pain
- ☐ Ache
- ☐ Weakness
- ☐ Gripping

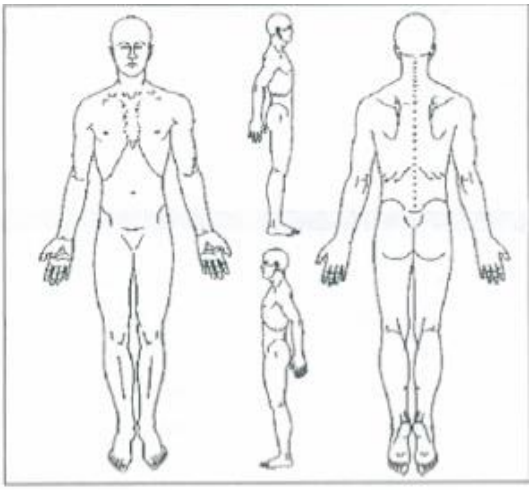
C. Frequency

- ☐ Constant (75-100%)
- ☐ Frequent (51 - 75%)
- ☐ Occasional (25 - 50%)
- ☐ Intermittent (25% or less)

D. Your symptoms are: ☐ decreasing ☐ not changing ☐ increasing

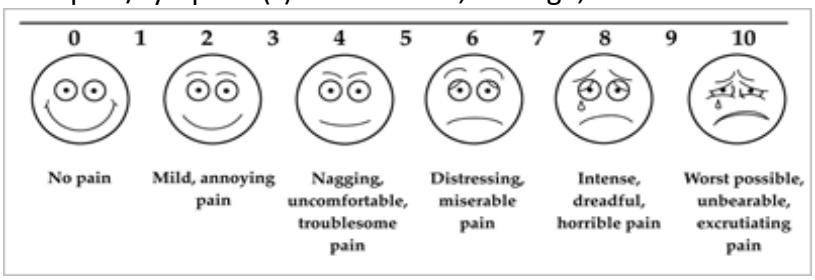
E. Symptoms are worse in the: ☐ Morning ☐ Night ☐ Increases during the day ☐ Same all day

F. Diagram / Visual Analog Scale:
Please mark the exact location(s) of pain/symptom(s) on the diagram.



Handed: Left Right

Please circle the number most representative of your pain/symptom(s) at their best, average, and worst.



Is your condition due to an accident? ☐ Yes ☐ No

Date of accident? _____

Type of accident? ☐ Auto ☐ Work ☐ At Home

☐ Other (Describe) _____

Have you ever been in an auto accident? ☐ Past Year

☐ Past 5 Years ☐ Over 5 Years ☐ Never

List all surgeries and episodes with stitches with dates:

_____

_____

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Please complete this general health 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 your case. THANK YOU.

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH QUESTIONNAIRE.

O = OCCASIONAL F = FREQUENT C = CONSTANT

O	F	C	GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles

			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction

O	F	C	EENT, Cont.
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

O	F	C	MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail-bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

			FEMALES ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

Are you pregnant? ☐ No ☐ Yes

CHECK ALL OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

Patient Name _____ Date _____

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Drugs you take now: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ Birth control pills ☐ "Pep" pills ☐ Tranquilizers

Others: _____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ In the past year ☐ In the past five years ☐ Over five years ago ☐ Never

Describe: _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DO YOU:			
Have an allergy to any drug?	☐	☐	_____
Think you may need vitamins/supplements?	☐	☐	_____
Now take vitamins/supplements?	☐	☐	_____
If yes, please list _____			

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

DATE OF LAST:	Less than 6 month	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Urine test	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home)

NAME: _____

ADDRESS: _____ PHONE: _____

Please provide us with your Drivers License and Insurance card(s)

Method of payment that will be used for today's visit:

☐ Cash ☐ Check ☐ Credit Card ☐ Auto Insurance Policy ☐ WC Policy

Payment Notice for Services Rendered: I (we) agree to pay Glencoe Family Chiropractic for services rendered to me or the patient listed above as charges are incurred. I understand and agree that health & accident insurance policies are a contract between an insurance carrier and myself and that I am ultimately and personally responsible for payments of any and all services, whether covered or not. Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made before seeing the doctor. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me are immediately due in full.

Patient Signature (or Guardian) _____ **Date** _____