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. How did it happen? (Context/Mechanism of Injury) _____

_____

C. Description of Symptoms/Quality

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

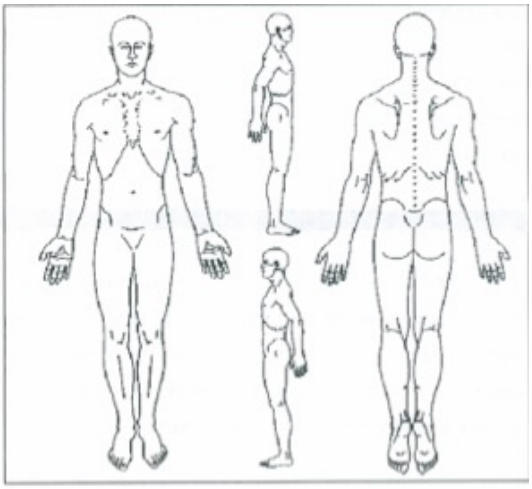
D. Frequency/Timing

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

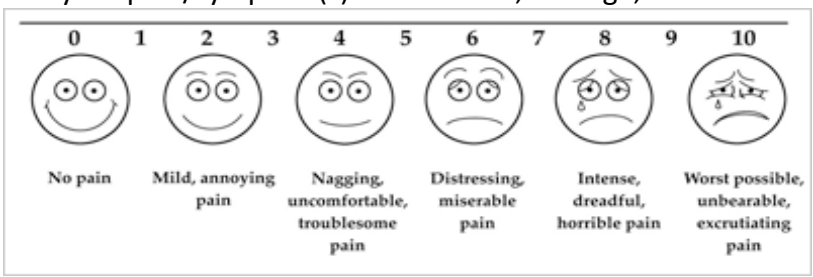
E. Your symptoms are: ☐decreasing ☐not changing ☐increasing

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

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



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



I. Duration: 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

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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

J. Review of Systems

O F C 1) GENERAL/CONSTITUTIONAL
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness/depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

2) EYES,
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Near sightedness

3) EARS, NOSE, MOUTH & THROAT
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental Decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noises
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Slow heart beat
- ☐ ☐ ☐ Swelling of ankles
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

O F C 4) CARDIO-VASCULAR
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heart beat

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

6) 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

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

O F C 8) 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

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

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

Office Use Only:

C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 S1 S2 S3 S4

K: Past History (PFSH)

CHECK ALL OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

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

Patient Name _____ Date _____

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(PFSH)

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

List all of the following you have had with dates:
Concussions _____ Fractures _____
Dental work _____ Stitches _____
Surgeries _____

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 _____

DATE OF LAST:	Less than 6 months	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 Driver's License and insurance information for Medicare, Medicaid, WC, Auto or Personal Injury accounts.

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

☐Cash ☐Check ☐Credit Card ☐HSA/Flex Acct. ☐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 _____