DEER CREEK CHIROPRACTIC **CONFIDENTIAL CASE HISTORY**

Date:___________________________

Name:____ Home Phone:___________________________________

Address: ____ City _______________________ Zip ______________

E-Mail Address ____ Cell Phone:____________________________________

Age: _____________ Birth date ____________________________ Marital Status: M S W D

Occupation: ___________________________________ Employer ____

Work Phone: ____ Can you take calls at work ? Yes No

Spouse Name: ____________________________________ How many Children ?______________________________

Ages of Children ________________________ How were you referred to our office? ______________________________

Family Medical Doctor __________________________________ Phone Number _______________________________

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office ? YES NO

HISTORY OF PRESENT ILLNESS: Reviewed with Patient ________

Chief Complaint: Purpose of this appointment: ____

Date Symptoms appeared or accident date: ____

Is this due to: ( ) Auto Accident ( ) Work Accident ( ) Other ____

Have you ever had the same or similar condition ? Yes No If yes, when and describe: ________________________

____

Days lost from work: _______________________ Date of last physical examination: ____________________________

What makes your condition worse: ____

What makes your condition better: ____

Is the pain (Circle all that apply) Constant —Aggravated by movement—Come and Go—Getting Worse—Same

Are you experiencing any: (Circle) Weakness—Radiating Pain—Dizziness—Nausea—Vomiting—Blurred Vision

Please indicate the level of pain you are currently experiencing by writing each involved body area on the scale below:

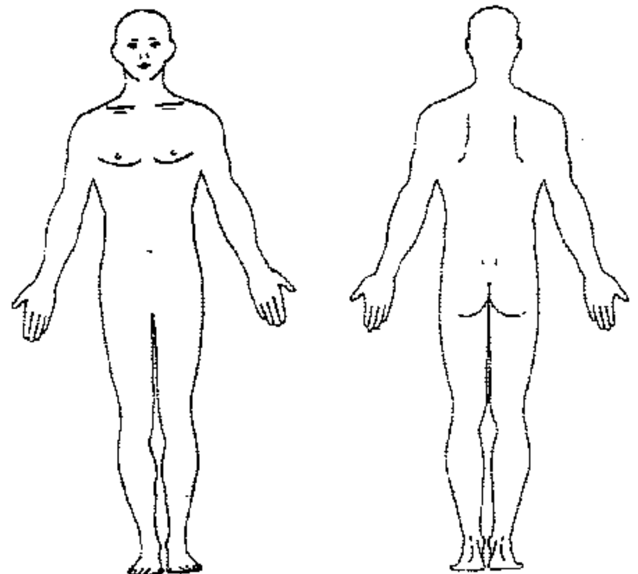
____

1 2 3 4 5 6 7 8 9 10
NO PAIN UNBEARABLE

On the diagram to the right please mark your areas of pain using the following symbols.

Please include all affected areas.

++ Numbness ## Weak
XX Burning ** Dull Aching
00 Pins & Needles == Other _______________
// Sharp



Please circle all the activities that you find difficult to do NOW due to your discomfort.

-Sleep through the night	-Sit in a chair for 30 minutes	-Put on socks, shoes, clothing
-Crawl on all fours	-Shovel snow or dirt	-Reach in front or overhead to high shelf
-Push or pull vacuum or lawn mower	-Wash, comb or dry hair	-Walk for one mile
-Get out of bed	-Sit and work at a desk for 1 hour	-Walk up one flight of stairs
-Carry laundry basket, groceries, or child	-Bend over to clean bathtub	-Stand for 30 minutes
-Turn door knob	-Bend over a sink for 10 min.	-Enjoy hobbies or social activities
-Make your bed	-Use pencil, scissors, screwdriver or pliers	-Walk down one flight of stairs
-Open a heavy door	-Get up from low seat	-Travel on journeys that take over 1 hour
-Wash windows or walls	-Go to the bathroom	-Enjoy sexual activities
-Bathe yourself	-Cross legs	
	-Lift heavy suitcase (about 40 lbs.)	

Are there any of the above activities that you had a difficult time doing before you had this discomfort?
____

Approximate Height ______________ Weight________________

PAST MEDICAL HISTORY

Reviewed with Patient ________

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or fractured bones	__Pace Maker	__Gall Bladder
__Osteoarthritis	__Drug Addiction	__Excessive bleeding
__Eating Disorder	__Seizures/Convulsions	__Ruptures
__Circulatory Problems	__Strokes	__Depression
__Epilepsy	__HIV Positive	__High/Low Blood Pressure
__Alcoholism	__A Congenital Disease	__Coughing Blood
__Rheumatoid Arthritis	__Cancer	__Ulcers
__Diabetes		

Do you have a history of stroke or hypertension? YES NO If YES, how long? ___________________________________

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):____
____

Have you been treated for any health condition by a physician in the last year? YES NO
If yes, describe: ____

What medications or drugs are you taking? ____
____

Do you have any allergies to any medications? YES NO
If yes, describe:____

Do you have any allergies of any kind? YES NO
If yes, describe:____

Please list any other health problems you have, no matter how insignificant they may be___________________________
____

WOMEN ONLY: Are you pregnant or is there any possibility that you may be pregnant?
Yes_______ No_______ Uncertain_______ Date of last menstrual period_______________

SOCIAL HISTORY:

Reviewed with Patient________

Do you drink alcoholic beverages? YES NO If so, how much per week? _________________________________
Do you use any tobacco products? YES NO Do you smoke? YES NO If so, packs per day: ______________
Do you take vitamin supplements? YES NO If so, please list: ____
____
Do you consume caffeine? YES NO If so, how much per day? ____
Do you exercise? YES NO If yes, what is the frequency and type of exercise? _____________________
____
What are your hobbies?____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting_____ sitting_____ bending_____ working at a computer_____

FAMILY HISTORY:

Reviewed with Patient ________

Father: **living___ deceased___ Current age if living_________ Cause of death and age if deceased:_________________**
____

Mother: **living___ deceased___ Current age if living___ Cause of death and age if deceased:______________________**
____

Check if applicable to you: _______ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so please list:______________________
____
____

FAMILY DISEASES

(check if applicable and indicate whether family member is Father, Mother, Sister, Brother)

Tuberculosis____
Cancer____
Mental Illness____
Diabetes_____
Other____

Asthma____
Heart Disease____
Stroke____

Kidney Disease____
Lung Disease____
Arthritis____
Liver Disease____

AUTHORIZATION AND RELEASE: **I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.**
The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPAA NOTICE available at the front desk. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: ____ Date: __________________
Guardian's Signature Authorizing Care: ________________________ Date: _________________
Doctor's Signature: _______________________________________ Date: __________________