Confidential Case History

Date:_____

Name _____ Social Security # __ __ __ - __ __ - __ __ __ __
Address _____ City _____
State _____ Zip _____ Phone _____ Cell Phone _____
E-mail address _____
Birth date ____ / ____ / ____ Age _____ Marital status *S M D W* No. of children _____
Occupation _____ Employer _____
Employer's address _____ Work phone _____
Are you employed (Circle one) *Full time Part time Full time student Part time student*
Spouse _____ Occupation _____ Employer _____

Please describe your major complaints. _____

_____

_____

Location of pain _____
Is this the result of a specific incident? Explain. _____
Date symptoms appeared or accident happened: ____ / ____ / ____
Have you ever had the same or similar condition? *Yes No* If yes, please describe: _____

_____

What makes the problem worse? (Circle all that apply) *Standing Sitting Lying Bending Lifting Twisting Other (describe)* _____
Is there anything you can do to relieve the problem? *Yes No* If yes, describe. _____

_____

If no, what have you tried to do that has not helped? _____
Is this condition changing? *Worse Better Same Constant Comes and goes*
Does this condition interfere with: *Work Sleep Hobbies Family life Social life Daily activities (list)* _____ *Other* _____

Please check the appropriate line for any of the following symptoms that you now have or have had previously. We want all the facts about your health before we accept your case. This is a confidential report.

_____ Neck pain
_____ Neck stiffness
_____ Neck grating
_____ Neck tension
_____ Mid-back pain
_____ Mid-back stiffness
_____ Mid-back grating
_____ Low back pain
_____ Low back stiffness
_____ Low back grating
_____ Low back tension

Pain in:
_____ Shoulders
_____ Arms
_____ Hands
_____ Hips
_____ Legs
_____ Feet

Numbness in:
_____ Shoulders
_____ Arms
_____ Hands
_____ Hips
_____ Legs
_____ Feet

_____ Painful tailbone
_____ Sciatica
_____ Painful joints
_____ Swollen joints
_____ Bursitis
_____ Hernia
_____ Pinched nerves
_____ Headaches
_____ Migraines
_____ Dizziness
_____ Fainting
_____ Fatigue
_____ Anxiety
_____ Depression
_____ Bad moods and behavior
_____ Tremors
_____ Insomnia
_____ Sweats
_____ Chills
_____ Belching/gas
_____ Colon trouble
_____ Constipation
_____ Diarrhea
_____ Indigestion
_____ Hemorrhoids
_____ Nausea
_____ Gall bladder trouble

_____ Liver trouble
_____ Vomiting
_____ Stomachaches
_____ Asthma
_____ Allergies
_____ Sinus problems
_____ Tonsillitis
_____ Eye pain
_____ Ringing in the ears
_____ High blood pressure
_____ Low blood pressure
_____ Chest pains
_____ Poor circulation
_____ Chronic cough
_____ Difficulty breathing
_____ Bedwetting
_____ Blood in urine
_____ Frequent urination
_____ Painful urination
_____ Kidney trouble
_____ Prostate trouble
_____ Menstrual cramps
_____ Excessive flow
_____ Irregular cycle
_____ Pregnancy
_____ Menopausal symptoms
_____ Lumps in breast

Conditions:
_____ Alcoholism
_____ Anemia
_____ Arteriosclerosis
_____ Arthritis
_____ Cancer
_____ Diabetes
_____ Drug abuse
_____ Epilepsy
_____ Heart disease
_____ Miscarriage
_____ Multiple sclerosis
_____ Polio
_____ Stroke
_____ T.B.
_____ Ulcers
_____ Mental disorders

Other:
_____
_____
_____
_____
_____
_____

Is this condition due to (Circle one) *Auto accident* *On-the-job injury* *Other* _____
Have you seen any other doctors for this condition? *Yes* *No* Their name(s) _____
That doctor's diagnosis: _____
Results: *Good* *Fair* *Poor* *None*
Other complaints or comments: _____
_____
_____

Have you ever been in an auto accident or had other serious injuries? *Yes* *No* If yes, please describe and give dates and/or ages. _____
_____

Broken Bones? _____
_____

Surgeries? _____
_____

What prescription medications are you taking and for what symptoms? _____
_____

Name and practice location of prescribing doctor: _____
Have you ever been hospitalized? *Yes* *No* If yes, please describe and give dates and/or ages:
_____
_____

Have you been treated for any other health condition in the past year? *Yes* *No* If yes, please describe. _____
_____

Have you been under chiropractic care before? *Yes* *No* Doctor's name: _____
Doctor's practice location: _____ Date of last adjustment: _____ / _____ / _____

In addition to your spouse, whom should we contact in case of an emergency? Relationship: _____
Name: _____ Phone: _____ Address: _____

Name and practice location of primary care physician: _____

Please check the type of care you desire so that we may be guided by your wishes when possible.
_____ I prefer the doctor to select the type of care that he feels is best for me.
_____ I would like to see maximum improvement of my condition.
_____ I would like temporary relief.

AUTHORIZATION AND RELEASE: *I authorize Dr. Fink to release all information necessary to secure the payment of benefits directly to this office. 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. I understand that interest is charged on overdue accounts at the annual rate of 18%.*

Patient's/Guardian's Signature _____ Date _____

How did you hear about our office? (Circle one) *Sign* *Yellow Pages* *Newspaper*
Coupon *Friend:* _____ *Other:* _____

WOMEN ONLY: Are you pregnant, or is there any possibility that you may be pregnant? *Yes* *No*