

PS CHIROPRACTIC PATIENT CASE HISTORY



Personal Information

Last Name _____ First Name _____ Middle Initial _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
Date of Birth: _____ age _____ Social Security #: _____ - _____ - _____ Gender: Male Female
Email Address: _____ Occupation: _____
Employer/School _____ Phone: _____ - _____ - _____
Spouse's Name _____ D.O.B. _____ SSN _____ - _____ - _____
Spouse's Employer _____ Phone: _____ - _____ - _____
In case of emergency, contact _____ Relationship _____
Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

Insurance Information

Who is responsible for this account? _____ Relationship to Patient _____
Insurance Company _____ Group # _____
ID # _____
Is Patient covered by additional insurance? No Yes
Subscriber's Name _____ D.O.B. _____ SSN _____ - _____ - _____
Relationship to Patient _____
Insurance Company _____ Group # _____

Assignment and Release

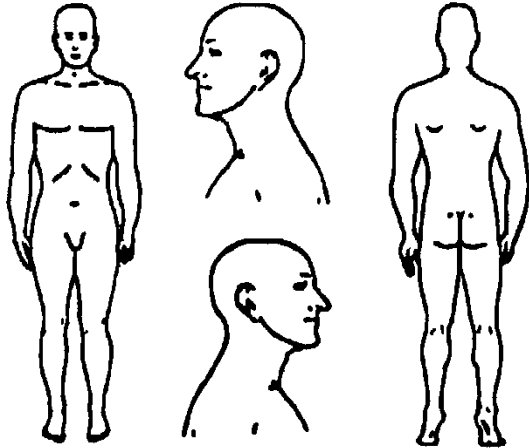
I certify that I, and/or my dependent(s), have insurance coverage with _____ (insurance co) and assign directly to Drs. Ben and/or Pam Avritt all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctors may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature _____ Date _____
Print Name _____ Date _____
Relationship to Patient _____

Patient Condition

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW
(mark ALL areas with XXXXXXXX)



Main reason for consulting our office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

What is your MAJOR complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

- Constantly (76-100% of the day) Frequently (51-75% of the day)
- Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain
 Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

- 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Are there any other Health Concerns that you would like to talk to us about? _____

Have you ever been to a Chiropractor before? No Yes - How long ago? _____

Whom may we thank for referring you? How did you find out about us? _____

Allergies

- Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen
 Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

Surgeries

- Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____

Past Medical History

- Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression
 Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain
 Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure
 Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain
 Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's
 Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain
 Stroke/Heart Attack Other: _____

Medications

- Anxiety Muscle Relaxors Pain Killers Insulin Birth control Cardiovascular Allergy Seizure
 Other: _____

Do you take Vitamins/Supplements No Yes

Family History

(PLEASE WRITE INITIAL BESIDE DISEASE: (M) MOM, (D) DAD, (B) Brother, (S) Sister, (G) Granparent

- Arthritis___ Asthma___ Back Pain___ Cancer___ Depression___ Diabetes___ Epilepsy___
 Genetic Spinal Condition___ High Blood Pressure___ Heart Problems___ Multiple Sclerosis___
 Neurological Problems___ Parkinson's___ Polio___ Prostate Problems___ Stroke/Heart Attack___
 Other: _____

Have you had any auto or other accidents? No Yes

Describe: _____

Have you ever cracked or broken a rib? No Yes - when?_____ how?_____

Do you have pain when you cough, sneeze, or bear down to go to the bathroom? No Yes

Date of last physical examination: _____

Do you smoke? No Yes

Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often): _____