A Family Chiropractic Office, P.C.
116 E. Riverside Blvd.
Loves Park, IL 61111
(815) 633-7000
www.afamilychiropracticoffice.com

PATIENT HISTORY

NAME _____ TODAY'S DATE: ___/___/___ DATE OF BIRTH: ___/___/___

___/___/___

SOCIAL SECURITY #:

MARITAL STATUS: SINGLE MARRIED DIVORCE
WIDOW SEPERATED

ADDRESS: _____ SPOUSE / PARTNER'S NAME: _____

CITY: _____ STATE: ____ ZIP: _____ SPOUSE / PARTNER'S DATE OF BIRTH: ___/___/___

E-MAIL: _____ EMPLOYER: _____

PHONE: (H) _____ (CELL) _____ PHONE (W) _____ ext. _____

IN CASE OF AN EMERGENCY, WHOM SHOULD WE NOTIFY: _____

PHONE NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

WHAT BRINGS YOU TO OUR OFFICE

PRESENT COMPLAINT:

1)_____

2)_____

3)_____

REMARKS AND DETAILS OF ANY ACCIDENT:

_____

_____

- DATE SYMPTOM FIRST APPEARED: _____
- DID IT BEGIN: _____GRADUAL _____ SUDDEN _____ PROGESSIVE OVER TIME
- WHAT MAKES THE SYMPTOM INCREASE? _____
- WHAT RELIEVES THE SYMPTOM? _____
- TYPE OF PAIN: _____ SHARP _____ DULL _____ACHE _____BURN _____THROB
- DO YOU EXPERIENCE NUMBNESS OR TINGLING? _____ Y _____N
- HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS?

_____ 100% _____75% _____50% _____25% _____10%

PAIN INTENSITY:

PLEASE CIRCLE A NUMBER BELOW DESCRIBING THE INTENSITY OF YOUR PAIN

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

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PATIENT HISTORY PART 2

PLEASE LIST ALL PREVIOUS TREATMENTS FOR THIS CONDITION:

NAME OF PRIMARY CARE PHYSICIAN: _____ TREATMENT DATES:_____

TYPE OF TREATMENT OR DRUGS PRESCRIBED: _____

_____

_____

NAME OF TREATING PHYSICIAN/SPECIALIST: _____ TREATMENT DATES:_____

TYPE OF TREATMENT OR DRUGS PRESCRIBED: _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE?_____ YES _____ NO

NAME OF CHIROPRACTOR:_____ DATES OF TREATMENT: _____

REASON:_____

_____

_____

PLEASE LIST ALL PAST SURGERIES:

TYPE: _____ DATE: _____ DOCTOR: _____

TYPE: _____ DATE: _____ DOCTOR: _____

TYPE: _____ DATE: _____ DOCTOR: _____

TYPE: _____ DATE: _____ DOCTOR: _____

PLEASE LIST ALL PREVIOUS ACCIDENTS AND FALLS:

TYPE: _____ DATE: _____

TYPE: _____ DATE: _____

TYPE: _____ DATE: _____

TYPE: _____ DATE: _____

PLEASE LIST ALL MEDICATIONS OR VITAMINS YOU ARE CURRENTLY TAKING:

TYPE: _____FOR HOW LONG? _____

TYPE: _____FOR HOW LONG? _____

TYPE: _____FOR HOW LONG? _____

TYPE: _____FOR HOW LONG? _____

PATIENT SIGNATURE_____ **DATE** _____

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME: _____ BIRTH DATE: ___ / ___ / ___ DATE: _____
HEIGHT: _____WEIGHT: _____ SEX: ___M ____F CASE NO: _____

PLEASE CHECK THE APPROPRIATE BOX FOR ANY TYPE 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 REPORT**.

OCCASIONAL	FREQUENT		OCCASIONAL	FREQUENT		OCCASIONAL	FREQUENT	
		GENERAL			**GASTRO-INTESTINAL**			**RESPIRATORY**
		Allergy (list below)*			Colon Trouble			Chest Pain
		Convulsions			Constipation			Chronic Cough
		Dizziness or Fainting			Diarrhea			Difficult Breathing
		Headache			Difficult Digestion			Spitting Up Blood
		Neuralgia			Distension of Abdomen			Spitting Up Phlegm
		Numbness			Gall Bladder Trouble			Wheezing
		MUSCLE & JOINT			Hemorrhoids			**SKIN**
		Arthritis			Liver Trouble			Bruise Easily
		Bursitis			Pain Over Stomach			Dryness
		Foot Trouble			**EYES, EARS, NOSE & THROAT**			Skin Eruptions (rash)
		Low Back Pain			Asthma			Varicose Veins
		Neck Pain or Stiffness			Colds			**GENITO-URINARY**
		Pain Between Shoulders			Deafness			Bed-Wetting
		Sciatica			Earache			Blood in Urine
		Swollen Joints, Pain, numbness or Cramps			Ear Discharge			Frequent Urination
		Shoulders			Ear Noises			Inability to Control Kidneys
		Arms			Eye Pain			Kidney Infection or Stone
		Elbows			Nasal Obstruction			Painful Urination
		Hands			Nose Bleeds			Prostate Trouble
		Hips			Sinus Infection			Pus in Urine
		Legs			**CARDIO-VASCULAR**			**FOR WOMEN ONLY**
		Knees			Hardening of the Arteries			Congested Breasts
		Feet			High Blood Pressure			Cramps or Backache
A Family Chiropractic Office					Low Blood Pressure			Excessive Menstrual Flow
					Pain Over Heart			Hot Flashes
					Poor Circulation			Irregular Cycle
					Rapid Heart Beat			Lumps in Breast
					Slow Heart Beat			Menopausal Symptoms
					Swelling of Ankles			Painful Menstruation
								Vaginal Discharge
								Pregnant Yes No
								Date of Last Period ___ / ___ / ___
								Previous Miscarriages Yes No

DATE OF LAST: (Approx.)

_____Physical Examination _____Dental X-Ray

_____Blood Test _____Urine Test

_____Chest X-Ray

_____Spinal X-Ray

HAVE YOU EVER:

Been Knocked Unconscious
Yes_____ No_____

Used a crutch, or other support?
Yes_____ No_____

Been treated for a spine or nerve Disorder?
Yes_____ No_____

Had a fractured bone?
Yes_____ No_____

Been hospitalized? (other than surgery)
*Yes_____ No_____
* If yes, explain below:

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

AIDS	Cancer	Epilepsy	Malaria	Pneumonia	Tuberculosis
Alcoholism	Chicken Pox	Foot Problems	Measles	Polio	Typhoid Fever
Anemia	Diabetes	Goiter	Multiple Sclerosis	Rheumatic Fever	Ulcers
Appendicitis	Eczema	Gout	Mumps	Scarlet Fever	Venereal Disease
Arteriosclerosis	Emphysema	Heart Disease	Pacemaker	Stroke	

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment against the Doctor's recommendation, my account balance will be immediately due and payable. I understand and agree that no auto, workman's comp, or liability insurance will be billed at any time. These insurance claims will be the patient's sole responsibility.

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely. Your signature is also acknowledging and agreeing with the financial responsibility statement stated above.

_____ _____ _____

Name (printed) **Signature** **Date**

FOR OFFICE USE ONLY:

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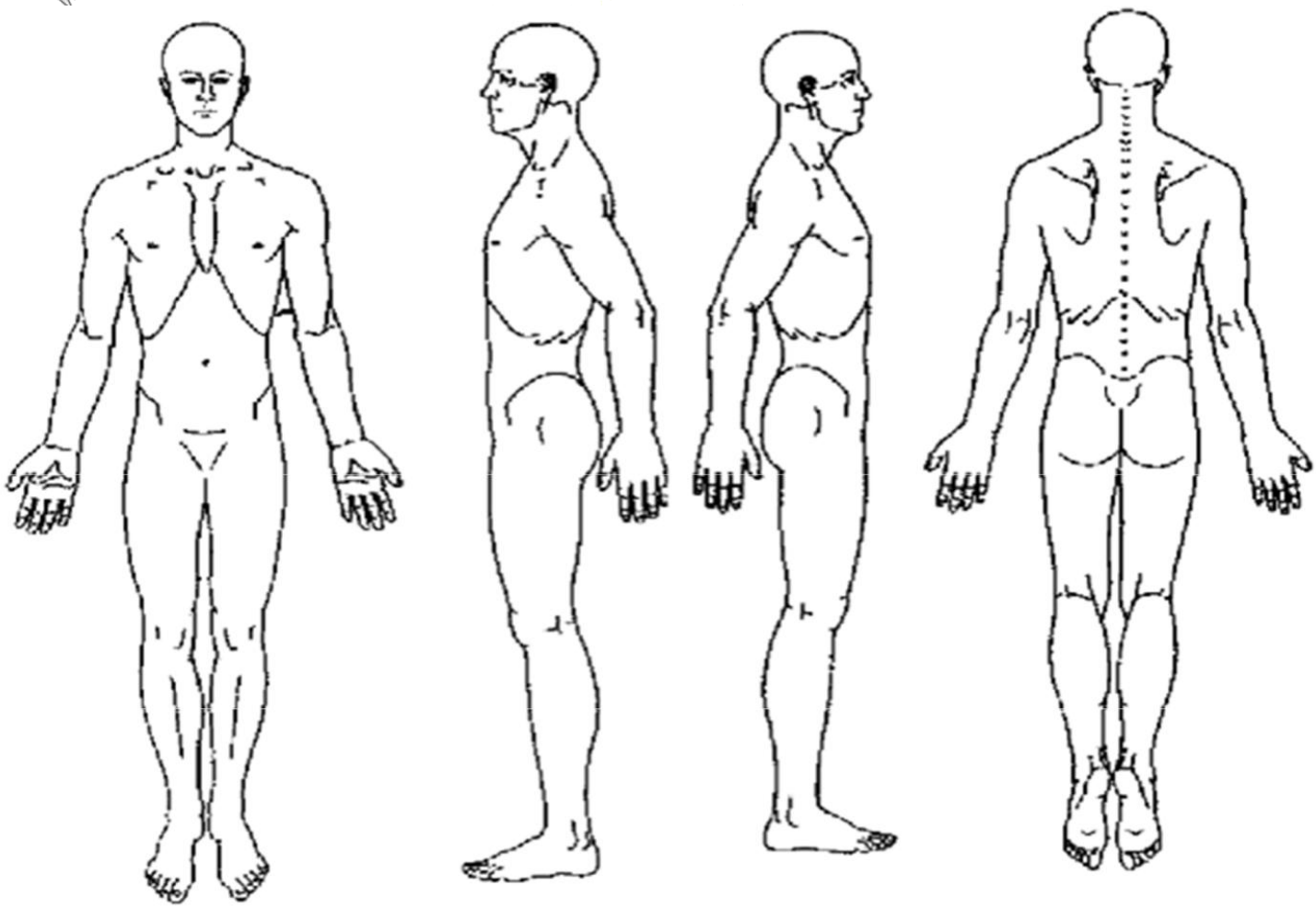
PAIN DIAGRAM



Please mark the areas of your complaint on the diagram above. Please use the following symbols to accurately describe your condition:

PP --Where you experience PAIN

NN --Where you experience NUMBNESS

TT-- Where you experience TINGLING

BB-- Where you experience BURNING

CC--Where you experience CRAMPING

PATIENT SIGNATURE _____ **DATE** _____