Park Ridge
CHIROPRACTIC

CASE HISTORY
CONFIDENTIAL INFORMATION FORM

Patients Name_____Date_____
Soc Sec #_____Home Phone ( )_____Cell Phone ( )_____
Address_____City_____Zip Code_____
E-Mail Address_____
Age_____Birth Date___/___/_____Marital Status: M S W D How Many Children_____
Occupation_____Employer_____
Employer Address_____Work Phone_____
Name of Insurance Policy Holder_____Soc Sec #_____
Name of Insurance Company_____Address_____
Name of Spouse_____Occupation_____
Employer_____Address_____
Patient's Nearest Relative_____Address_____
Phone_____Referred By_____

Are you here due to injuries suffered in a work accident?_____
Are you here due to injuries suffered in a Auto accident?_____
Have you ever had the same or similar condition?_____If so, when?_____
Have you lost any days from work?_____If so, how many?_____
Have you ever had an operation?_____If so, when?_____
Have you had any serious illness?_____
Have you ever been under chiropractic care before?_____If so, where?_____
Female: Are you currently pregnant? Yes No
Date your last menstrual period began_____

Do You:

Smoke Cigarettes	Yes	No	Occasionally
Drink Alcohol	Yes	No	Occasionally
Exercise	Yes	No	Occasionally
Take Vitamins	Yes	No	Occasionally

Do you have a family history of:

Heart Disease	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Other	Yes	No

Major Complaint_____
_____

How long have you had this condition?_____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

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Do you know what may have caused this condition?_____
Have you had this or similar conditions in the past?_____
What activities aggravate your condition?_____
Does your condition interfere with your:

Work	Yes	No
Sleep	Yes	No
Daily Routine	Yes	No

Other_____

Have you seen any other doctor's regarding this condition? (Please specify names and dates)
_____

Are you currently taking any prescriptions or over the counter medications?_____
If so, please list_____

Do you have a regular doctor or someone you consult about maintaining your health?_____
_____

Do you consider yourself a healthy person? Yes No

What positive changes would better health provide for you?_____
_____

Are you interested in learning about how to prevent health problems for yourself and your family?
Yes No

Do you practice healthy eating habits? Always Occasionally Rarely
Are you interested in learning more about nutrition and exercise? Yes No

PAYMENT OF THE FIRST VISIT IN FULL IS REQUIRED

Person responsible for payment_____
Are you insured? Yes No Name of Insurance Company_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me to be credited to my account 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 any fees for professional services rendered me will be immediately due and payable.

Patients Signature_____Date_____

Guardian or Spouse's Signature authorizing care_____Date_____
Information taken by_____

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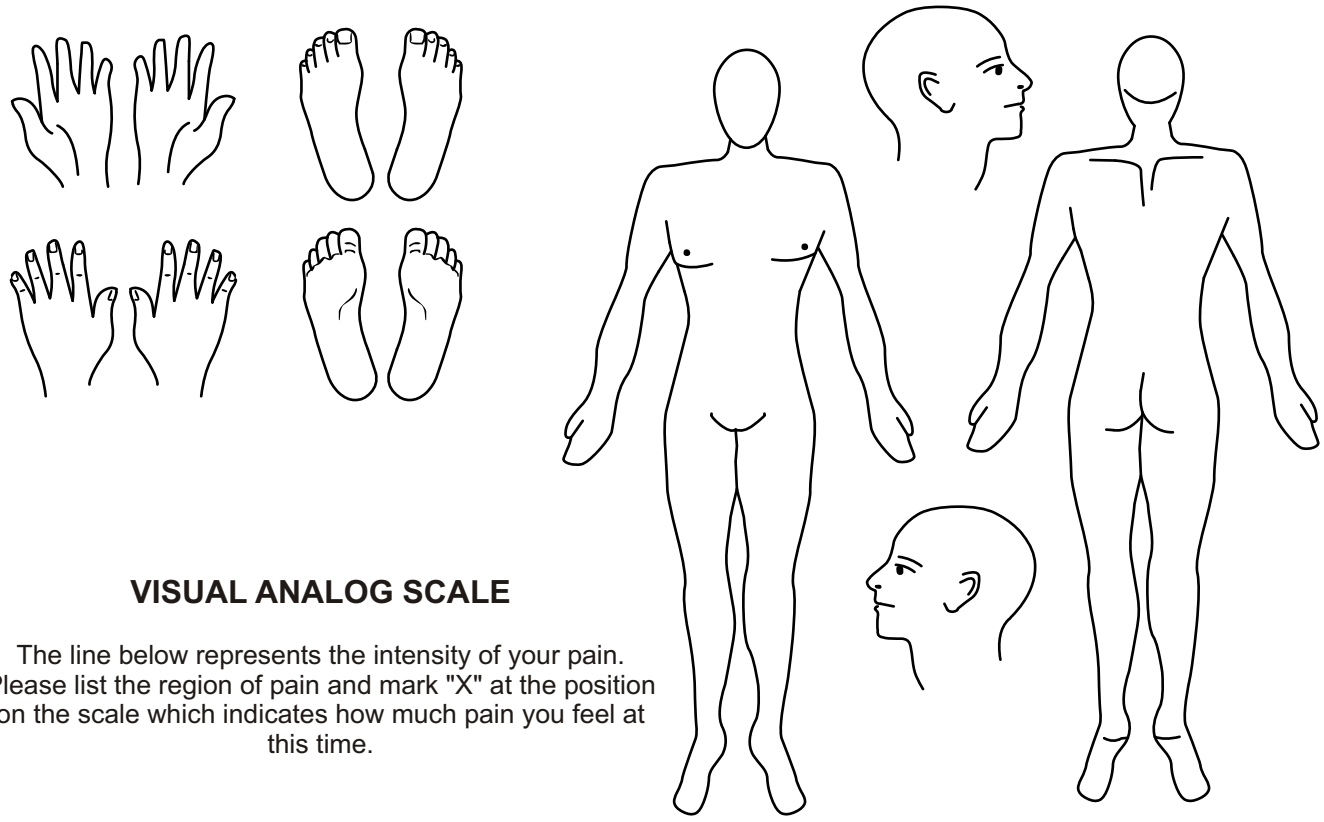
PAIN DRAWING
TELL US WHERE YOU HURT

Please read carefully:
Mark the areas on your body where you feel pain. Include all the affected areas and mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrows as far as the pain travels. Use the appropriate symbol(s) listed beiow.

ACHE	**>>>>**	**NUMBNESS**	**====**	**PINS AND**	**0000**
	>>>>		**====**	**NEEDLES**	**0000**
BURNING	**xxxx**	**STABBING**	**/ / / /**	**THROBBING**	**++++**
	xxxx		**/ / / /**		**++++**



VISUAL ANALOG SCALE

The line below represents the intensity of your pain. Please list the region of pain and mark "X" at the position on the scale which indicates how much pain you feel at this time.

Ex. Neck
NO PAIN_____WORST PAIN IMAGINABLE

1._____
_____

2._____
_____

3._____
_____