CONFIDENTIAL PATIENT CASE HISTORY

Patient's Full Name: _____ Social Security #: _____

Mailing Address:_____
City State Zip Code

Date of Birth: _____ Home Phone #: _____ Cell Phone #: _____

Email: _____

Preferred Language: _____ Race:_____ Ethnicity: _____

Patient Occupation: _____ Employer: _____

Work Address: _____ Work Phone #: _____
City State Zip Code

Family Physician: _____ Other Physicians you see: _____

Emergency Contact: _____ Relationship:_____ Phone #:_____

INSURANCE INFORMATION (if already obtained by our staff, skip this section)

Primary Insurance: _____

*Please provide front office with your insurance card.
**If you have secondary insurance please provide card.

PLACE A CHECK IF YOUR SYMPTOMS ARE RELATED TO:

☐ Auto Accident Date of Accident: _____

☐ Work Injury Date of Injury: _____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

Please initial each statement after reading it:

____I authorize this office to release my medical information to any other requesting party.

____I authorize the release of my medical records from any other doctor's office or hospital to this office.

____I authorize my insurance company to pay this office directly for covered services rendered by Dr. Kevin Small and I am financially responsible for any existing co-payments or deductibles due. I am financially responsible in full for all services rendered that are not covered by my insurance or if my insurance benefits are exceeded. If I do not have health insurance, I am financially responsible for all charges at the time of service.

____If the patient is a minor; I hereby authorize examination and treatment by Dr. Kevin Small, D.C.

Signature of Patient (or legal guardian): _____

Date: _____

For what condition(s) or symptom(s) are you being seen for (migraines, neck pain, etc)?

_____

When did these symptoms start? _____

How did they start? _____

What have you tried for symptom relief? (Ice/heat, aspirin, etc.) _____

Has it been effective? _____

What activities aggravate your condition? _____

Have you been seen by anyone else for this? _____ If so, who? _____

Have you had anything like this before? _____

Are your symptoms:

□ sharp	□ stabbing	□ dull/achy
□ tingling	□ weakness	□ numbness
□ tight/stiff	□ throbbing	□ other _____

Place a mark on the scales below describing your level of pain (or other symptoms):

Today: _____

No pain worst pain imaginable

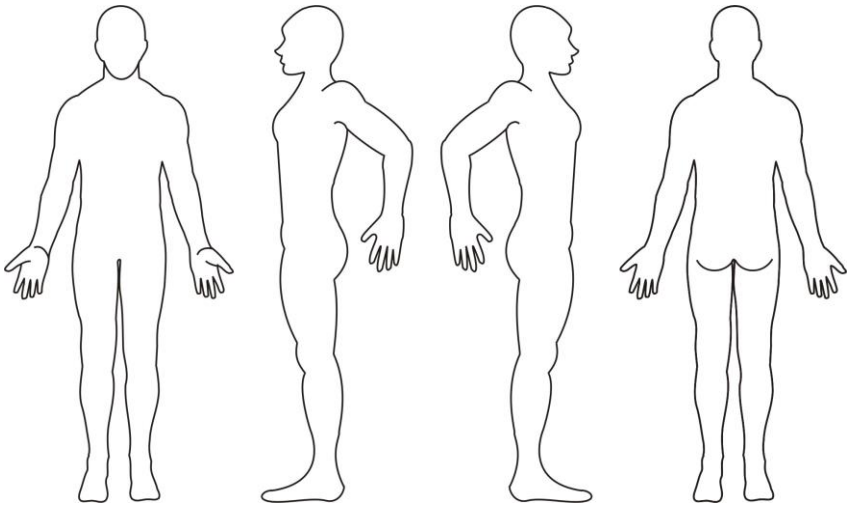
At worst: _____

No pain worst pain imaginable

At best: _____

No pain worst pain imaginable

PLEASE INDICATE WHERE YOU EXPERIENCE YOUR SYMPTOMS IN THE FIGURES BELOW:



My symptoms limit these activities:
-Check all that applies-

□ Bending/twisting
□ Child care/playing with kids
□ Dressing
□ Exercise
□ Hobbies
□ Lifting/carrying
□ Personal hygiene
□ Reaching overhead
□ Reading/desk work
□ Sexual activity
□ Sitting
□ Sleeping
□ Standing
□ Tying shoes
□ Urination or bowel movements
□ Using stairs
□ Work duties
□ Other _____

Have you <u>ever</u> been treated or evaluated by a:

□ chiropractor	□ orthopedist/neurologist
□ physical therapist	□ naturopathic doctor
□ massage therapist	□ acupuncturist

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Kenneth Wheelock, D.C. • Kevin Small, D.C.

Height: _____ Weight: _____ Age: _____ Dominant Hand: _____Right _____ Left
Smoking(circle one): Never Former Smoker Current Smoker Decline to Disclose

List all current medications (RX or over-counter) and reason taken: _____

_____

List any allergies: _____

List present or past health conditions (diabetes, high blood pressure, etc.): _____

_____

List past surgeries/hospitalizations (estimate dates): _____

_____

List previous injuries/accidents (estimate dates): _____

Review of systems – Please check all that applies –

□ Visual or hearing change/disturbance
□ Headaches
□ Jaw pains/clicking/locking
□ Poor sleep
□ Clinical depression
□ "Totally stressed-out"
□ Dizziness/fainting
□ Allergies; medical/food/environmental
□ Weakness, fatigue or energy changes
□ Intolerant to heat or cold
□ Chest pain or difficult breathing
□ Heart murmur/palpitations
□ Nausea/vomiting/abdominal pain
□ Heart burn/indigestion
□ Urinary Problems
□ Diarrhea/constipation
□ Sexual/reproductive problems
□ Menstrual problems
□ I am pregnant □ I might be pregnant
□ Unexplained weight gain/loss
□ Night pain
□ Numb/tingling/coldness in arms or legs
□ Memory loss/difficult concentration

Family History
Are there diseases/illnesses that run in your family? (Cancer, arthritis, heart problems, etc.): _____

_____

Socioeconomic History

Describe your typical work duties: _____

How long have you been employed at your present job? _____

Have you lost work time because of your condition? _____ If yes, how much? _____

Have you received time loss compensation? _____ Have you had a previous disability? _____

Marital Status: □ Married □ Single □ Widowed □ Divorced

Number of children: _____ Ages: _____

Education/Training: _____

Military Experience: □ Yes □ No If yes, any service-related disability? □ Yes □ No