AMERICAN CHIROPRACTIC CENTER

Please Print Neatly

Name _____ Age____ Sex: M____ F____ Date_____

Address_____ City_____ State_____ Zip _____

Home ( ) _____ Birth Date _____ Social Security # _____

Cell Phone _____ Patient's Email Address _____

Occupation _____ Employer _____ Work Phone _____

To Whom May We Thank for Referring You? Patient_____

SBC Phone Book _____ Yellow Pages _____ Internet _____ Other _____

In Case of Emergency, whom should we notify? _____

Phone _____ Relationship _____

Name of Insurance _____ Name of Insured _____ Insured DOB _____

I do not have insurance _____

Your Medical Doctors _____ City _____ Last Visit _____ Reason:_____

_____ City _____ Last Visit _____ Reason:_____

Have you ever been to a chiropractor? Yes _____ No _____ Name of chiropractor _____

Last treatment date: _____ REASON:

Results were: Favorable _____ No Improvement _____

I acknowledge that a "Notice of Privacy Practices" is available for my review: (Patient Initials) _____

My current injury is related to: Work _____ Auto _____ Neither _____ Patient Initials: _____

Please describe your major complaints and symptoms that you are here for:

Date you first noticed the problem:_____ **Is it better?** Yes No **Is it getting worse?** Yes No

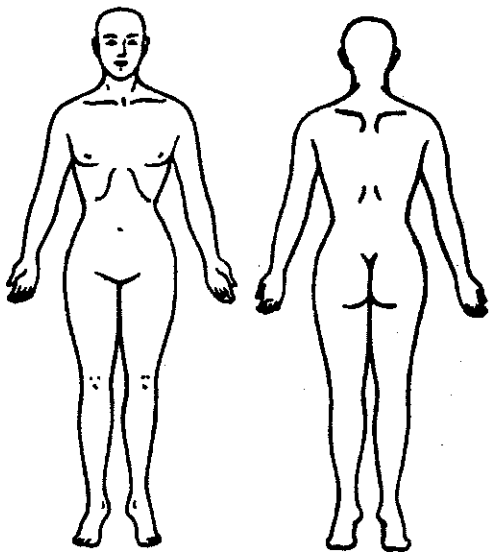
Has it stayed the same? Yes No **It started** *Gradually Rapidly* **Have you noticed the problem before?** Yes No

If so, when? _____ **Was it this bad?** Yes No **What, if anything gives you relief?** _____

Was there anything specific that started this? _____

Does the pain keep you up at night? Yes No **Does a certain position give you relief?** Yes No **What?** _____

Please X or Circle areas of pain or injury on the illustrations below and give a word description of the major symptoms and major complaints you are experiencing in those areas.



TURN PAGE OVER

Case History

Please mark the applicable boxes you now have or have had in the past.

☐ ☐ ☐ ☐ **1) Had but no longer an issue 2) Have Occasionally 3) Have Frequently 4) Have Constantly**
1 2 3 4

☐☐☐☐ Allergies_____
☐☐☐☐ Seizures/Convulsions---Grand Mal / Petite Mal
☐☐☐☐ Dizziness Fainting Lightheadedness
☐☐☐☐ Headaches (use head diagram)
☐☐☐☐ Loss of feeling _____
☐☐☐☐ "Pins & Needles"_____
☐☐☐☐ Psychiatric Problems_____
☐☐☐☐ Osteoarthritis (where?)_____
☐☐☐☐ Bursitis (where?)_____
☐☐☐☐ Foot problems (what?) _____
☐☐☐☐ Lower back pain
☐☐☐☐ knee pain Left Right
☐☐☐☐ Artificial joints (where?) _____
☐☐☐☐ Neck pain and/or Neck stiffness
☐☐☐☐ Tight shoulders or between shoulder blades
☐☐☐☐ leg pain / sciatica (burns--tingles--sharp)

☐☐☐☐ Shoulder pain LEFT RIGHT
☐☐☐☐ Elbow pain LEFT RIGHT
☐☐☐☐ Wrist pain LEFT RIGHT
☐☐☐☐ Hip pain LEFT RIGHT
☐☐☐☐ Knee pain LEFT RIGHT
☐☐☐☐ Ankle pain LEFT RIGHT

☐☐☐☐ Colon problems_____
☐☐☐☐ Constipation
☐☐☐☐ Diarrhea
☐☐☐☐ Indigestion / Heartburn
☐☐☐☐ Ulcers - - Gastric or Duodenal
☐☐☐☐ Gas / Flatuence
☐☐☐☐ Hemorrhoids
☐☐☐☐ Liver problems: Type_____ Hepatitis Cirrhosis
☐☐☐☐ Autoimmune Disorders_____
☐☐☐☐ Skin rashes _____

☐☐☐☐ Asthma
☐☐☐☐ Bronchitis
☐☐☐☐ Sinus Infections
☐☐☐☐ Colds
☐☐☐☐ Ear Infections
☐☐☐☐ Tinnitus (Ear noises / Ringing)
☐☐☐☐ Nose bleeds
☐☐☐☐ Shingles

☐☐☐☐ High blood pressure
☐☐☐☐ Low blood pressure
☐☐☐☐ High cholesterol #_____
☐☐☐☐ Hardening of the arteries
☐☐☐☐ Chest pain (when) _____
☐☐☐☐ Poor circulation
☐☐☐☐ Bruise easily
☐☐☐☐ Rapid heart beat
☐☐☐☐ Slow heart beat
☐☐☐☐ Swelling (ankles / feet / hands)
☐☐☐☐ Chronic cough (since)_____
☐☐☐☐ Difficulty breathing
☐☐☐☐ Wheezing
☐☐☐☐ Spitting up: Blood Phlegm
☐☐☐☐ Varicose veins
☐☐☐☐ Pneumonia (Bacterial Viral)
☐☐☐☐ Pneumonia (Pneumocystic)

☐☐☐☐ Bed wetting
☐☐☐☐ Blood in urine
☐☐☐☐ Frequent urination _____x's /day
☐☐☐☐ Bladder incontinence
☐☐☐☐ Kidney (Stones Infections)
☐☐☐☐ Painful urination
☐☐☐☐ Foul smelling urine
☐☐☐☐ Prostate problems PSA_____#

Please list any drugs that you routinely take _____

Please list any past surgeries and when _____

_____

Have you ever been knocked unconscious? Y N When? _____ Why? _____
Have you ever used a crutch or cane? Y N When? _____ What for? _____
Have you been treated for a spine or nerve disorder? Y N When _____ What for? _____
Have you had any fractures? Y N When? _____ What? _____
Have you ever been Hospitalized? Y N When? _____ What for? _____
List any past serious accidents. When? _____ What? _____

DATE OF LAST:

Complete physical _____
Blood tests _____
Urine tests _____
Chest x-ray _____
Spinal x-rays _____
Dental x-rays _____
Eye exam _____

HABITS: (what & quantity)
Alcohol _____
Coffee # cups / day _____
Tobacco _____# / day ____

☐ ☐ ☐
1 2 3

1) Have 2) Had
3) Family Member

☐☐☐ Alcoholism ☐☐☐ Asthma ☐☐☐ Cancer _____ ☐☐☐ Diabetes ☐☐☐ Emphysema
☐☐☐ Heart Disease or Attack ☐☐☐ Multiple Sclerosis ☐☐☐ Rheumatic Fever ☐☐☐ Stroke
☐☐☐ Tuberculosis ☐☐☐ HIV AIDS date diagnosed _____ ☐☐☐ _____
☐☐☐ Drug Abuse Pregnant Yes No Osteoporosis Yes No

I am interested in more information regarding: ☐ Decompression Therapy ☐ Acupuncture ☐ Massage Therapy

My signature verifies that the information above is true and completely accurate _____

Print Name:_____ Date_____