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CONFIDENTIAL CASE HISTORY

Dear Patient,

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond effectively, we will not accept your case. Thank You.

PATIENT INFORMATION (Please Print Clearly)

Name: _____ Social Security #:_____-_____-_____

Address: _____City: _____State: _____Zip:_____

Home No.:_____ Work No.:_____ Mobile No.:_____

E-Mail Address: _____ *Circle Preferred Communication Type*

Birth Date: ____/____/_____ Age: _____ Sex: M F Marital Status: M S W D DP

Spouse/Dom. Partner's Name: _____

Who Were You Referred By: _____

Emergency Contact Name/Relation: _____Telephone No.:_____

Occupation Status: _____Your Occupation: _____

Employer Name: _____ Employer Telephone No.:_____

Employer Address: _____ City: _____ State: _____ Zip: _____

Language: _____Race: _____ Ethnicity: _____ Religion: _____

Smoking/Tobacco Status: _____ Alcohol Use/Amount per Week: _____

Primary Care Physician: _____Telephone No.:_____

Chief Complaint: _____

When did your pain/symptoms begin? _____

Other Complaints: _____

Age of Mattress: _____Years · Comfortable · Uncomfortable

Are you wearing: · Heel Lifts · Sole Lifts · Inner Soles · Arch Supports

Have you been in an auto accident: · Past Year, · Past 5 Years, · Over 5 Years, · Never

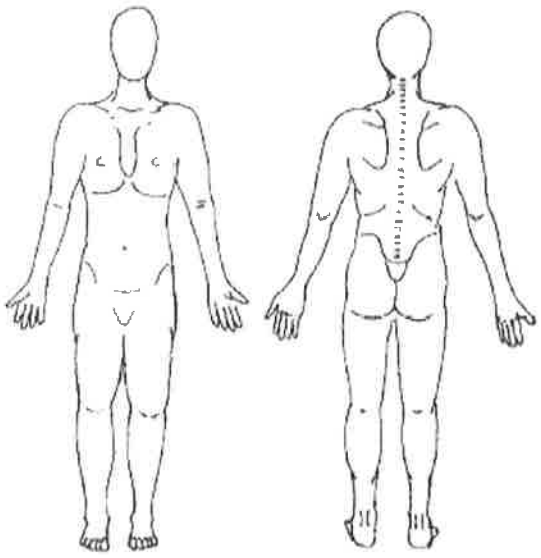
If Yes, describe injuries sustained:

_____

_____

Have you had a personal injury accident/ work mans compensation: · Past Year, · Past 5 Years,

· Over 5 Years, · Never



Please mark the following that apply on the picture:

(P-Pain, N-Numbness, T-Tingling, B-Burning,
W-Weakness, S-Swelling, X-Stiffness, O-Soreness)

I experience this pain/problem:

- The entire day
- Most of the day (16-20 hours)
- A good part of the day (8-15) hours
- A fair amount of the day (2-7 hours)
- A small amount of the day (1 hour or less)
- Less than once per day
- N/A

What were you doing when the pain presented itself?

_____

Onset? _____ · Days · Weeks · Months · Year(s) Ago · I don't know

Have you ever had anything like this before? · No · Yes When? _____

Since it began, has it been: · Better · Worse · About the same · I don't know

Does it travel/radiate? · No · Yes, where? _____

Numbness or Tingling? · No · Yes, where? _____

Weakness? · No · Yes, where? _____

Bowel/Bladder Dysfunction? · No · Yes · Not applicable

Unexplained weight loss? · No · Yes _____ **Pain coughing/sneezing?** · No · Yes _____

What makes it better? _____

What makes it worse? _____

The Pain is: · Intermittent · Constant · Dull · Achy · Sharp · Stabbing · Burning · Other_____

Severity: Least 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Worst

Does it interrupt sleep? · No · Yes

Time of day it gets worse? · Upon waking up · Morning · Afternoon · Evening · Right before bed

Have you been to any other healthcare providers for this? · No · Yes

When? _____What was the outcome of treatment? _____

Films: · None · X-rays · MRIs · CT · Other films.

What and when? _____

Facility? _____

Have you been hospitalized? · No · Yes

When/Why? _____

Surgeries: · No · Yes

Date	Type	Reason for Surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Activities of Daily Living:

(Please indicate which activities are compromised by your current health status)

· Sitting · Standing · Walking · Leaning forward (brushing teeth, vacuuming, ironing, doing dishes etc.) · Bending forward · Lying on your side with knee's bent · Lying on your back · Lying on your stomach · Rising from sitting · Changing positions · Coughing/sneezing · Exercise · Physical activity · Lifting/straining · Bowel movements · Turning head · Looking up (neck extension) · Looking down (neck flexion) · Going up stairs · Going down stairs · combing hair · shaving · driving · Other: _____

· Allergies · Pregnant?? · Dizziness · Neuritis · nervousness · Neck pain · Sinus trouble · Headache type: _____ · Other: _____

Are you currently taking ANY over-the-counter medication? ____Yes ____No

Are you currently taking ANY prescription medication? ____Yes ____No (list name and condition)

Drug/Dose	Condition	Drug/Dose	Condition	Drug/Dose	Condition
_____		_____		_____	
_____		_____		_____	

Please list any **allergies** or adverse reactions you have had. Please include date of last episode:

_____

_____

FAMILY INFORMATION: Check all that apply and **label there relation to you**

(Many health problems are the result of hereditary weakness thus information about your family members will give us a better picture of your total health)

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

· None of these · Stroke · Heart trouble · Kyphosis · Diabetes · Cancer · Arthritis · Lung Disease
· Osteoporosis · Migraines · High blood pressure · Scoliosis · Spine problems · Hip Replacement
· Alcohol dependence · Aneurysm · other: _____

REVIEW OF SYSTMES – (Check if you have had trouble with any of the following within the last 3 months)

General:
__Weight Change
__Fever
__Chills
__Night Sweats
__Weakness
__Fatigue

Eyes:
__Vision
__Pain
__Discharge

Ears:
__Hearing
__Ringing
__Pain
__Discharge

Nose:
__Pain
__Bleeding
__Taste

Skin:
__Rash
__Itching
__Hair Changes
__Nail Changes

Neurologic:
__Headache
__Dizziness
__Fainting
__Convulsions

G-I:
__Appetite
__Abdominal Pain
__Vomiting
__Diarrhea
__Constipation

G-U:
__Frequent Urination
__Painful Urination
__Incontinence

Cardio:
__Murmur
__Chest Pain
__Palpitations
__Difficulty Breathing
__Cough
__Wheezing
__Blue Extremities
__Swollen Extremities

Breasts:
__Mass
__Pain
__Discharge
__Self -exam

Psychologic:
__Anxiety
__Depression
__Moods
__Memory

Musculoskeletal:
__Neck
__Upper Extremities
__Upper Back
__Lower Extremities
__Lower Back

INSURANCE INFORMATION:

Primary Insurance Co: _____

Subscriber Name: _____Subscriber DOB: ___/___/___ Subscriber SS#___/___/___

Insurance ID#: _____Group #:_____

(If patient is a minor, please provide us with their individual ID number not that of the patient.)

Insurance Address: _____ Insurance Phone No.:_____

Secondary Insurance Co: _____

Subscriber Name: _____Subscriber DOB: ___/___/___ Subscriber SS#___/___/___

Insurance ID#: _____Group #:_____

(If patient is a minor, please provide us with their individual ID number not that of the parent.)

Insurance Address: _____ Insurance Phone No.:_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and I. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to Chiropractic Office will be credit to my account upon receipt. However, I clearly understand and agree that I am responsible for payment in full at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due immediately payable Dr. Robert DeStefano Chiropractic & Associates, LLC.

CREDIT CARD: MC VISA AMEX DISCOVER (Please Circle):

Card #:_____Exp Date: _____

Patient's Signature: _____Date:_____

Guardian or Spouses' Signature_____