

CASE HISTORY

Name: _____ Age: _____ Today's Date: _____
Address: _____ City: _____ State: _____
Zip: _____ E-mail: _____ Date of Birth: _____ MALE / FEMALE
Phone: (H) _____ (C) _____ (W) _____ SSN#: _____

Marital Status: S M D W Occupation: _____ Employer: _____
Spouse's Name: _____ Spouse's SSN#: _____
Insurance Company: _____ Insured's Name: _____ Insured's DOB: _____

Past Chiropractic Care: Y / N When? _____ Results: _____
Past Chiropractor's Name: _____ Telephone #: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about our office?

Are your current problems related to an injury sustained during one of the following:

On the Job: _____ Auto Accident: _____ Other: _____

If other, please describe:

Has the Accident been reported? Y / N To Whom? Employer ____ Auto Carrier ____ Other ____

Are you or have you ever been disabled?(Service or Work) Y / N When?

Why?

Have you retained an attorney? Y / N Name & Phone #:

Pain/Symptoms: Let us know your symptoms today in order of severity & circle pain scale.

1. _____ Began: _____
0 1 2 3 4 5 6 7 8 9 10 (0 = No Pain / 10 = Intense Pain)

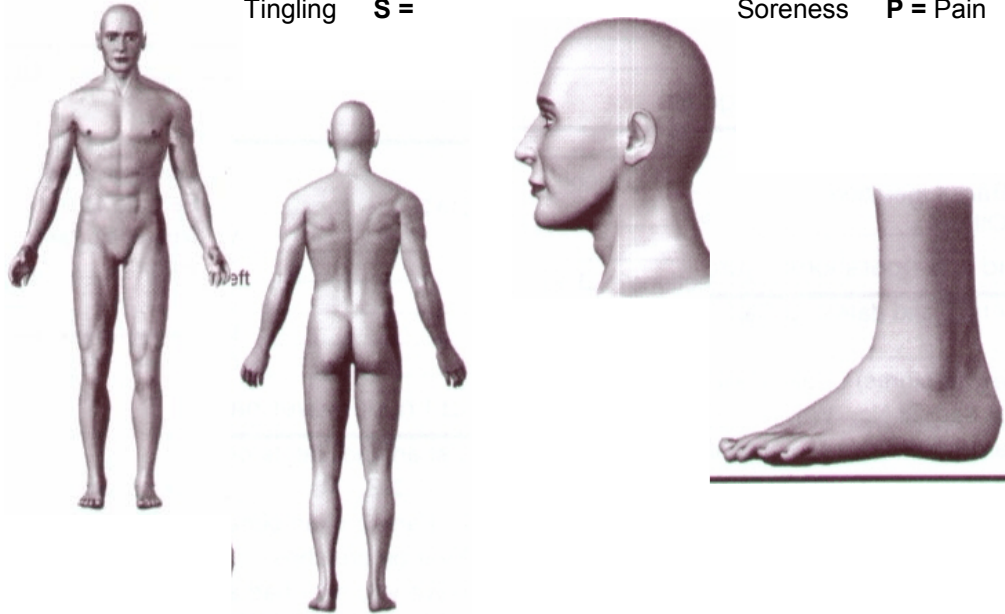
2. _____ Began: _____
0 1 2 3 4 5 6 7 8 9 10 (0 = No Pain / 10 = Intense Pain)

3. _____ Began: _____
0 1 2 3 4 5 6 7 8 9 10 (0 = No Pain / 10 = Intense Pain)

Case History

Please mark areas & type of pain on the drawing using the codes provided below:

N = Numbness **T** = Tingling **S** = Soreness **P** = Pain **A** = Ache
ST = Stiffness



Habits:

Smoking: Y / N Pack/Day: _____
 Drinking: Y / N Alcohol: _____
 Caffeine: Y / N Cups/Day: _____

Family History

M = Mother **B** = Brother
F = Father **S** = Sister
 Diabetes ___ Kidney ___ Heart ___
 Cancer ___ Other ___

Exercise: None Light Activity Moderate Active Very Active Elite Athlete

Have you had, or do you have any of the following? N = Now Have P = Previously

Appendicitis	N / P	Anemia	N / P	Pneumonia	N / P
Whooping Cough	N / P	Asthma	N / P	Measles	N / P
Mumps	N / P	Chicken Pox	N / P	Diabetes	N / P
Cancer	N / P	Migraines	N / P	Heart Disease	N / P
Goiter	N / P	Influenza	N / P	Alcoholism	N / P
Mental Disorder	N / P	Epilepsy	N / P	Eczema	N / P
Arthritis	N / P	Multiple Sclerosis	N / P		

General Symptoms:

Allergy	N / P	Bronchitis	N / P	Chills	N / P
Nervousness	N / P	Dizziness	N / P	Fainting	N / P
Fever	N / P	Loss of Sleep	N / P	Headache	N / P
Sweats	N / P	Convulsions	N / P	Loss of Weight	N / P
Wheezing	N / P	Neuralgia	N / P	Depression	N / P

Skin or Allergies:

Hives or Allergy	N / P	Itching	N / P	Dryness	N / P
Bruising Easily	N / P	Sensitive Skin	N / P	Skin Eruptions	N / P

Gastro-Intestinal:

Diarrhea	N / P	Constipation	N / P	Belching/Gas	N / P
Abdominal Pain	N / P	Nausea	N / P	Jaundice	N / P
Hemorrhoids	N / P	Excessive Eating	N / P	Vomiting	N / P
Indigestion	N / P	Liver Trouble	N / P	Rectal Bleeding	N / P
Poor Appetite	N / P	Poor Digestion	N / P	Gall Bladder Trouble	N / P
Vomiting Blood	N / P	Excessive Thirst	N / P		

Senses:

Deafness	N / P	Earache	N / P	Ear Discharge	N / P
Crossed Eyes	N / P	Ear Noises	N / P	Hay Fever	N / P
Hoarseness	N / P	Enlarged Thyroid	N / P	Poor Vision	N / P
Nosebleeds	N / P	Frequent Colds	N / P	Nasal Obstruction	N / P
Pain in Eyes	N / P	Sore Throat	N / P	Bleeding Gums	N / P
Persistent Cough	N / P	Tonsillitis	N / P		

Respiratory:

Chest Pain	N / P	Chronic Cough	N / P	Spitting Blood	N / P
Difficulty Breathing	N / P				

Muscles/Joints/Bones:

Backache	N / P	Foot Trouble	N / P	Stiff Neck	N / P
Tremors/Twitching	N / P	Swollen Joints	N / P	Arm Trouble	N / P
Hernia	N / P	Painful Tail Bone	N / P	Spinal Curvature	N / P
Pain between Shoulders	N / P				

Cardio-Vascular:

Pain Over Heart	N / P	Poor Circulation	N / P	Heart Trouble	N / P
Slow Heart	N / P	Varicose Veins	N / P	Rapid Heart	N / P
High Blood Pressure	N / P	Low Blood Pressure	N / P	Swelling Ankles	N / P

Genito-Urinary:

Bed Wetting	N / P	Blood in Urine	N / P	Kidney Infection	N / P
Frequent Urination	N / P	Painful Urination	N / P	Lack of Bladder Control	N / P

Operations and Procedures:

Date		Date		Date	
_____	Vaccinations	_____	Tonsillectomy	_____	Gall Bladder
_____	Back Operation	_____	Sinus	_____	Tubes in the Ears:
_____	Appendectomy	_____	Female Organs	_____	Rectal Surgery
_____	Hernia	_____	Thyroid	_____	Stomach
_____	Other:	_____	Other:	_____	Other:

_____ **I have never had any operations or surgeries**

For Women Only:

Irregular Cycle	N / P	Hot Flashes	N / P	Miscarriage	N / P
Cramps or Backache	N / P	Excessive Flow	N / P	Painful Periods	N / P
Lump in Breast	N / P	Vaginal Discharge	N / P		

Are you pregnant at this time? Y / N

Have you had a mammogram? Y / N

Date of Last Pap Smear:

By Whom?

Please list the following:

Any accidents or falls and their dates:

Car Accidents:

Recreational Accidents:

Sports Accidents:

School Accidents:

Other Accidents:

Any broken bones, including fractures and dislocations:

Have you ever had a Spinal Tap or Spinal Injection? Y / N If yes, why?

Have you ever had X-Rays taken? Y / N if yes, when and by whom?

What was the reason for these X-Rays being made?

Do you suffer from any condition other than the one for which you are now consulting us? Y / N

If yes, please explain:

Are you presently taking any medication prescription or over-the-counter? Y / N

If yes, please list :

I understand and agree that all services rendered to me are my own personal responsibility and I agree to make payment for these services to Beachy Family Chiropractic. I understand that the office will submit my claims to my Insurance Company, but will not accept assignment from them. I am responsible for paying all of my bills at the time of service. Should third party collections become necessary, I agree to pay all fees involved in collection of the account. Furthermore, I agree that any unpaid balances will be charged a 2% per month charge until payment is made in full.

I also acknowledge that the Dr. and his staff cannot be held responsible for any incorrect information I might have submitted to them. I authorize the Doctor to examine and treat my condition as deemed necessary, and I give my authority for these procedures to be performed. The amount paid to the Doctor's office for X-Rays is for the examination only; the X-Ray negatives will remain the property of Beachy Family Chiropractic and will remain on file as long as I am a patient. I am the responsible party for this account and for payment of any and all services accrued on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Print Name: _____ Date: _____

Signature: _____ Date: _____

I authorize Dr. Matthew Beachy and staff to treat my minor child with or without my presence being required at every visit. My permission has been given for _____ to sign for their visits if I am not present at their appointment.

Patient's Name: _____ Date: _____

Parent / Guardian : _____ Date: _____