

Koch Chiropractic Center

CONFIDENTIAL PATIENT CASE HISTORY

Date: _____

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you.

Name: _____ Nickname: _____ You're-mail address: _____

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

Home Telephone: _____ Cell Phone _____ Birth Date: _____ Age: _____

married single widowed divorced Spouse's Name: _____ # of Children: _____

Employer, Address, and Telephone: _____

Occupation and general description of physical activities involved: _____

Have you had previous chiropractic care? yes no If so; Where: _____ When: _____

Were x-rays taken? yes no What was your problem at that time: _____

How were you referred to our office?: _____

GENERAL HEALTH INFORMATION:

Personal History

Your approximate Height: _____ Weight: _____ Is your weight constant? yes no

Please check if you have ever suffered from: Cancer of any type Heart Disease Diabetes

Digestive disorders Bladder or Bowl problems High blood pressure, or any other vascular disease

Stroke or TIA Arthritis Breathing difficulties Slurred Speech or Partial Paralysis Allergies

Any other illness or disease: _____

Do you exercise? never occasionally frequently What kind of exercise? _____

Do you use tobacco? no yes Do you Drink alcohol? no socially occasionally frequently regularly

Other activities you participate in, i.e. sports, hobbies etc: _____

Who is your Medical Doctor: _____ Date of last physical exam: _____

Any problems found: _____

All medications you are taking: _____

Please list any surgical procedures you have had, and the year: _____

Past history of any significant physical trauma, fractures, auto accidents, or other injuries (please describe): _____

Family History

Family Health History: Please list any major health problems your family has had, and their relationship to you: _____

CURRENT REASON FOR CONSULTING THIS OFFICE:

What is your chief complaint: _____

Any other complaints: _____

How long have you had this problem(s): _____

Have you seen anyone else for this condition(s), if so, who, what was done, and results: _____

PLEASE FILL OUT OTHER SIDE

Is your condition getting progressively worse? yes no Have you had similar problems before? If so, when, how often, etc.: _____

Was the onset of your current condition gradual or sudden? If sudden, what were you doing at the time it started?: _____

Please describe how it feels: sharp, dull, achy, numb, tingling, burning, stabbing, stiff, sore

Do you have any pain or numbness radiating into your arms or legs? yes no Where? _____

Is your condition constant, or does it come and go? Please describe _____

What seems to make your condition worse?: _____

What seems to help?: nothing or _____

Is there a time when it is worse? ie. morning, winter, during menstrual period? _____

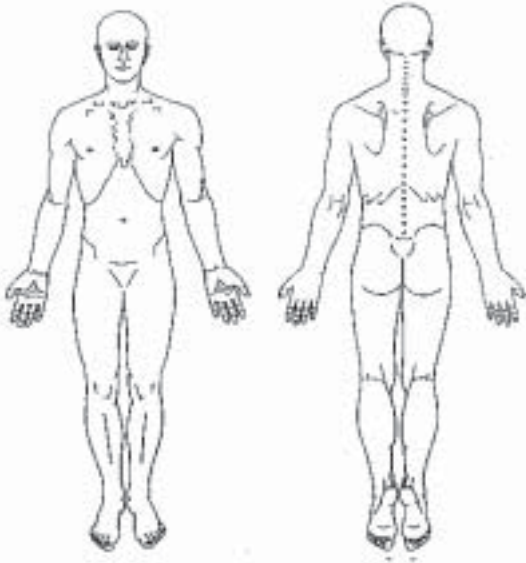
On a scale of 1 to 10, with 1= no pain and 10 = severe pain, what would you rate your primary complaint?: _____

How about your other complaints? _____

Is your condition causing any interference in your activities of daily living, i.e.; work, sleep, lifting, bending, driving, home care, sexual relations, etc. please describe in detail: _____

Are there any activities that you were able to do before but are unable to do now because of this pain? ie. lifting children, walking at the mall, sitting at the movies, gardening, etc. _____

Please use the letters listed to indicate the type and location of your pain & sensations:



- A = Ache**
- N = Numbness**
- B = Burning**
- P = Pins and Needles**
- S = Stabbing**
- O = other**

INSURANCE INFORMATION:

PLEASE GIVE YOUR INSURANCE CARD TO OUR CHIROPRACTIC ASSISTANT.

Is your condition due to an auto accident or job related injury? yes no

Do you have health insurance? yes No If so, what is the name of the company _____

Policy #: _____ Group#: _____

Name the policy is in, if other than yourself, and their relation to you : _____

Their date of birth: _____ Their Social Security #: _____

Do you have a secondary insurance? yes No Policy #: _____ Group #: _____

If your insurance is an HMO or PPO, do you need to have a referral from your primary care physician? yes no

How will you plan to pay for today's visit? cash check Visa/MC/Discover

Patient Signature _____ Date: _____