

CARAOTTA CHIROPRACTIC ORTHOPEDICS



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Chiropractic Case History/Patient Information

Date _____ Patient # _____ Doctor _____

Name _____ Social Security # _____ - _____ - _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

E-mail address _____ Fax# _____ Cell Phone _____

Age _____ Birth Date _____ Race _____ ****MARITAL: M S W D** How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer _____

Name of Nearest Relative _____ Address _____ Phone _____

How were you referred to our office? _____

Family Medical Doctor _____

Purpose of this appointment _____

Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work _____

Date of last physical examination _____ ****WHAT SURGERIES HAVE YOU HAD (include dates)** _____

Serious illness (include dates) _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

****WHAT MEDICATIONS ARE YOU TAKING?** _____

****DO YOU HAVE ANY ALLERGIES?** Yes No If yes, describe _____

Please check any and all insurance coverage that may be applicable in this case.

Major Medical Worker's Compensation Medicaid

Medicare Auto Accident Other

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

Turn page to continue

CHECK THE FOLLOWING SYMPTOMS YOU HAVE HAD:

GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor Circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
 - Shoulders
 - Arms
 - Elbows
 - Hands
 - Hips
 - Legs
 - Knees
 - Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal curvature
- Swollen joints

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed Eyes
- Deafness
- Dental decay
- Earache
- Ear discharge
- Ear noises
- Enlarges glands
- Enlarged thyroid
- Eye Pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus Infection
- Sore throat
- Tonsilitis

RESPIRATORY

- Chest Pain
 - Chronic Cough
 - Difficult breathing
 - Spitting up blood
 - Spitting up phlegm
 - Wheezing
- GASTRO-INTESTINAL**
- Belching or gas
 - Colitis
 - Colon trouble
 - Constipation
 - Diarrhea
 - Difficult digestion
 - Distension or abdomen
 - Excessive hunger
 - Gall bladder trouble
 - Hemorrhoids
 - Intestinal worms
 - Jaundice
 - Liver trouble
 - Nausea
 - Pain over stomach
 - Poor appetite
 - Vomiting
 - Vomiting of blood

SKIN

- Boils
 - Bruise Easily
 - Dryness
 - Hives or allergy
 - Itching
 - Skin eruptions (rash)
 - Varicose veins
- GENITO-URINARY**
- Bed wetting
 - Blood in urine
 - Frequent urination
 - Inability to control kidneys
 - Kidney infection or stones
 - Painful urination
 - Prostate trouble
 - Pus in urine
- FOR WOMEN ONLY**
- Congested breasts
 - Cramps or backache
 - Excessive menstrual flow
 - Hot flashes
 - Irregular cycle
 - Menopausal symptoms
 - Painful menstruation
 - Vaginal discharge

HAVE YOU EVER:

	YES	NO
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Had a fracture bone?	<input type="checkbox"/>	<input type="checkbox"/>
Been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU:

Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>
*HAVE DIABETES?	<input type="checkbox"/>	<input type="checkbox"/>

DATE OF LAST	Less than	Over	18 months	Never
	6 months	6-18months		
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS (CIRCLE ONE FOR EACH)

*ALCOHOL	Heavy	Moderate	Casual	None		
*COFFEE (drinks per day)	6	3-6	0-3	None		
*TOBACCO	Former	Current	Never			
*NON PRESC. DRUGS	YES	NO	IF YES, EXPLAIN _____			
*EXERCISE	Daily	Weekly	Walks	Runs	Swims	Never
Sleep	Heavy	Moderate	Light	None		
Appetite	Heavy	Moderate	Light	None		

ARE YOU PREGNANT? YES NO

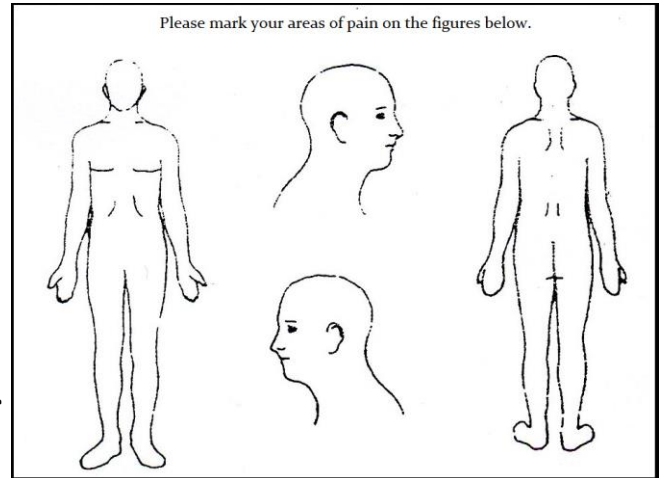
PLEASE CHECK THE TYPE OF CARE YOU DESIRE SO THAT WE MAY BE GUIDED BY YOUR WISHES WHEN POSSIBLE

- I PREFER THE DOCTOR TO SELECT THE TYPE OF CARE HE/SHE FEELS IS BEST FOR ME
- MAXIMUM IMPROVEMENT
- TEMPORARY RELIEF

DESCRIBE BRIEFLY

*** FAMILY HISTORY: (PLEASE LIST FAMILY MEMBER [MOTHER, FATHER, ETC.] NEXT TO CONDITION)**
CANCER _____ **HIGH BLOOD PRESSURE** _____
DIABETES _____ **STROKE** _____
OSTEOPOROSIS _____ **OTHER** _____

*** HEIGHT** _____ **WEIGHT** _____
*** (FOR DR'S USE ONLY) BP** _____ / _____ **PULSE** _____



ARE YOU INSURED? YES NO **COMPANY** _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICE RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

Patients Signature _____

Date _____

Guardian or Spouse's
Signature Authorizing Care _____

Date _____

Information taken by: _____