CONFIDENTIAL CASE HISTORY

oakbaychiropractic
family and sports care

NAME: LAST	FIRST	MIDDLE	SEX	AGE	BIRTH DATE	TODAY'S DATE

STREET ADDRESS			MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	WEIGHT	FEMALES: ARE YOU... PREGNANT?_____ LMP_____
CITY	STATE	ZIP	SOCIAL SECURITY #		OCCUPATION
HOME PHONE	BUSINESS PHONE		REFERRED BY	REFERRED TO	DRIVER'S LICENSE #
E-MAIL ADDRESS			AUTO ACCIDENT ☐	MEDICARE ☐	MEDI-CAL ☐ BLUE CROSS ☐ WORKER'S COMP ☐
NEXT OF KIN	RELATIONSHIP		OTHER INSURANCE COMPANY		NO COVERAGE ☐
STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)			NAME OF INSURED PERSON		IDENTIFICATION #
CITY	STATE	ZIP			
YOUR EMPLOYER'S NAME & ADDRESS					
STREET ADDRESS					
CITY	STATE	ZIP			

ASSIGNMENT AND RELEASE:
I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE UNDERSIGNED PHYSICIAN. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED.

SIGNED_____
(PATIENT SIGNATURE - OR PARENT SIGNATURE, IF PATIENT IS A MINOR)

DATE_____

WHY ARE YOU SEEING THE DOCTOR?

_____

_____

_____

THIS IS A NEW / OLD ILLNESS. IT WAS NOT / TREATED BEFORE.

IF TREATED BEFORE, WHAT WAS DONE?_____

_____

_____

WHEN?_____ BY WHOM?_____

HAVE YOU HAD PROBLEMS WITH THE FOLLOWING? ✓CHECK YES OR NO

	YES	NO		YES	NO
LUMPS	☐	☐	HEARING	☐	☐
MOLES	☐	☐	SEEING	☐	☐
SWELLING	☐	☐	SMELLING	☐	☐
STIFF JOINTS	☐	☐	RACING HEART	☐	☐
DIZZINESS	☐	☐	DIGESTION	☐	☐
BALANCE	☐	☐	WEIGHT	☐	☐
APPETITE	☐	☐	CONSTIPATION	☐	☐
SLEEPING	☐	☐	MOOD OR FEELINGS	☐	☐
BREATHING	☐	☐	(WOMEN ONLY)		
PAINS, ACHES	☐	☐	MENSTRUATION	☐	☐
HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE?				☐	☐

HAVE YOU BEEN X-RAYED BEFORE? WHAT PARTS?_____

_____

PAP SMEAR (WOMEN ONLY) NEVER ☐ DATE_____

CHEST X-RAY NEVER ☐ DATE_____

LAST MEDICAL EXAMINATION NEVER ☐ DATE_____

WHO IS OR WAS YOUR REGULAR DOCTOR?_____

_____

CITY AND STATE_____

PATIENT SIGNATURE_____

CHECK IF YOU OR A BLOOD RELATIVE HAVE HAD OR HAVE THESE:

	YOU	BLOOD RELATIVE		YOU	BLOOD RELATIVE
ANEMIA	☐	☐	KIDNEY/BLADDER TROUBLE	☐	☐
ASTHMA	☐	☐	MENTAL DISORDER	☐	☐
BLEEDING TENDENCIES	☐	☐	RHEUMATISM OR ARTHRITIS	☐	☐
CANCER OR TUMOR	☐	☐	STROKE	☐	☐
DIABETES	☐	☐	TUBERCULOSIS	☐	☐
EPILEPSY	☐	☐	ULCER/STOMACH TROUBLE	☐	☐
GLAUCOMA	☐	☐	NUMBNESS	☐	☐
GOUT	☐	☐	SCIATICA	☐	☐
HEART TROUBLE	☐	☐	HEADACHES	☐	☐
HIGH BLOOD PRESSURE	☐	☐	SCOLIOSIS	☐	☐

ARE YOU TAKING ANY MEDICATION?_____

SPECIFY_____

_____

HOW ARE YOUR DIETARY / NUTRITIONAL HABITS?_____

_____

_____

DO YOU EXERCISE REGULARLY?_____

EXPLAIN_____

_____

HAVE YOU EVER HAD SURGERY, OR BEEN HOSPITALIZED?
(WOMEN: DO NOT COUNT NORMAL BIRTHS)

YES ☐ NO ☐ IF YES, WHAT YEAR?_____

WHAT WAS WRONG?_____

_____

_____

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