

# New Patient Case History

E.G. Image (®)

Date \_\_\_\_\_ Case No. \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F Marital Status S M D W

Social Security # \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Number of Children \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Name & Address \_\_\_\_\_

Insurance Yes \_\_\_\_\_ No \_\_\_\_\_ Name \_\_\_\_\_

Are Your Injuries Due to an On-The-Job Injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Auto Accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Do You Plan on Turning it in to Workman's Compensation? Yes \_\_\_\_\_ No \_\_\_\_\_ Accident Date \_\_\_\_\_

Are You Now or Have You Ever Been Disabled (Service or Work) Yes \_\_\_\_\_ No \_\_\_\_\_ Dates \_\_\_\_\_

Referred By \_\_\_\_\_ Past Chiropractic Care Yes \_\_\_\_\_ No \_\_\_\_\_

Chiropractor's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

List Your Major Health Complaints & Areas of Pain: \_\_\_\_\_

Please check all of the following symptoms and signs which you have or have had within the last 6 months. An understanding of your health status will facilitate treatment.

## GENERAL SYMPTOMS

\_\_\_\_\_ Fever  
\_\_\_\_\_ Chills  
\_\_\_\_\_ Night Sweats  
\_\_\_\_\_ Fainting  
\_\_\_\_\_ Loss of Sleep  
\_\_\_\_\_ Fatigue  
\_\_\_\_\_ Nervousness  
\_\_\_\_\_ Loss of Weight  
\_\_\_\_\_ Numbness or Pain  
in arms, legs, hands  
\_\_\_\_\_ Allergies (What)  
\_\_\_\_\_ Headache  
\_\_\_\_\_ Dizziness  
\_\_\_\_\_ Tremors  
\_\_\_\_\_ Convulsions  
\_\_\_\_\_ Skin Eruptions/Problems  
\_\_\_\_\_ Painful Periods

## DIGESTIVE PROBLEMS

\_\_\_\_\_ Nausea, Stomach Upset  
\_\_\_\_\_ Heart Burn  
\_\_\_\_\_ Constipation  
\_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Vomiting  
\_\_\_\_\_ Pain Over Stomach  
\_\_\_\_\_ Difficulty Swallowing

## CARDIO-VASCULAR

\_\_\_\_\_ Rapid Heart  
\_\_\_\_\_ Slow Heart  
\_\_\_\_\_ High Blood Pressure  
\_\_\_\_\_ Low Blood Pressure  
\_\_\_\_\_ Pain Over Heart  
\_\_\_\_\_ Previous Heart Trouble  
\_\_\_\_\_ Strokes

## EYE, EAR, NOSE, THROAT

\_\_\_\_\_ Frequent Colds  
\_\_\_\_\_ Sinus Problems  
\_\_\_\_\_ Difficulty Breathing  
\_\_\_\_\_ Wheezing  
\_\_\_\_\_ Asthma  
\_\_\_\_\_ Pain in Eyes  
\_\_\_\_\_ Earache  
\_\_\_\_\_ Ear Noises  
\_\_\_\_\_ Nose Bleeds  
\_\_\_\_\_ Sore Throat  
\_\_\_\_\_ Chronic Cough

## MUSCLE & JOINTS

\_\_\_\_\_ Stiff Neck  
\_\_\_\_\_ Backache  
\_\_\_\_\_ Swollen Joints  
\_\_\_\_\_ Painful Tail Bone  
\_\_\_\_\_ Pain Between Shoulders

## HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES?

_____ Polio	_____ Lumbago	_____ Appendicitis	_____ Heart Disease	_____ Flu
_____ Anemia	_____ Eczema	_____ Alcoholism	_____ Malaria	_____ Measles
_____ Sciatica	_____ Mumps	_____ Epilepsy	_____ Chickenpox	_____ Cancer
_____ Diabetes	_____ Pneumonia	_____ Goiter	_____ Pleurisy	_____ Arthritis
_____ Rheumatism		_____ Typhoid	_____ Mental Disorders	

# OPERATIONS

Date \_\_\_\_\_

\_\_\_\_\_ Appendectomy  
\_\_\_\_\_ Back Operations  
\_\_\_\_\_ Female Organs  
\_\_\_\_\_ Gall Bladder

\_\_\_\_\_ Heart Surgery  
\_\_\_\_\_ Hernia Repair  
\_\_\_\_\_ Lung Surgery  
\_\_\_\_\_ Rectal Surgery

\_\_\_\_\_ Stomach Surgery  
\_\_\_\_\_ Thyroid Operation  
\_\_\_\_\_ Tonsillectomy  
Other \_\_\_\_\_

Major Falls or Accidents: (Childhood & Adult) \_\_\_\_\_

Broken Bones or Dislocations: \_\_\_\_\_

Were You Ever Knocked Unconscious? Yes \_\_\_\_\_ No \_\_\_\_\_

Have You Ever Had a Lapse of Memory? \_\_\_\_\_

Have You Ever Had X-Ray Pictures Made of Your Case? \_\_\_\_\_

If So, By Whom? \_\_\_\_\_

For What Ailments Were These Pictures Made? \_\_\_\_\_

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? \_\_\_\_\_

Are You Presently Taking Any Medication - Prescription or Patent? \_\_\_\_\_

If So, What Drugs? \_\_\_\_\_

Who Is Your Family Medical Doctor? \_\_\_\_\_

When Did You Last See Him/Her? \_\_\_\_\_

Why? \_\_\_\_\_

What Treatment Was Given (Drugs, Surgery, Therapy, Etc?) \_\_\_\_\_

Have You Consulted A Specialist? \_\_\_\_\_ Who? \_\_\_\_\_

Why? \_\_\_\_\_ What Treatment Did You Receive? \_\_\_\_\_

It is understood and agreed the amount paid to Palmer Chiropractic Center for X-Ray is for examination only, and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I understand that if my insurance company covers services and the check(s) is sent to the patient, it is the patient's responsibility to bring the check and explanation of benefits to this office. I understand and agree that if my insurance or Medicare fails to provide payment for services rendered that it is my responsibility to pay for these services. I understand that my insurance is a quote of benefits and not a guarantee of benefits. There is no guarantee until the Explanation of Benefits is received from the insurance company which takes approximately 30 days. Co-pays and/or deductibles that are left unpaid for more than 30 days will incur an 18% interest rate annually.

Signature \_\_\_\_\_ Date \_\_\_\_\_