Langholff Chiropractic and Wellness

PATIENT CASE HISTORY

Name: ______________________________ Date: ______________________

Address: ____

City State Zip

Birth date: _______________ Marital Status: M S W D Race: Caucasian Af-Am Hisp Other_______

Home Phone: _________________ Cell #: ___________________ Work: _________________

Email address: ______________________________ Like to receive our newsletter? Y N

Occupation: _________________________ Employer: ___________________________________

In case of emergency, contact person not living at your residence:

Name: ______________________________ Phone: _______________________

Present complaint: ____

When and how did it start? ____

Prior treatment for this complaint: ____

Have you had this previously? ☐ Yes ☐ No If so, when? ______________________________

Other health concerns you would like to discuss: ____

When was your last physical examination? ___________ Family physician: _________________

What kind of care are you seeking? ☐ Pain relief for current problem

☐ Improve overall health and well being

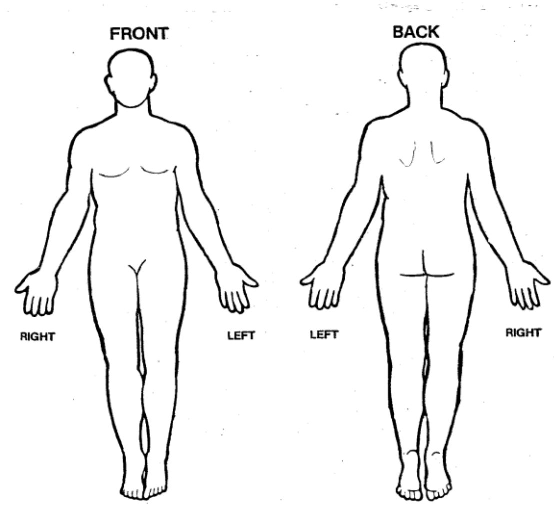
Have you been seen by a chiropractor before? _________ If so, when? _____________________

How did you hear about our office? Phone Book/ Insurance/Referral/Other____________________

Can we thank someone for referring you? ____

1) PAIN DRAWING: Using the appropriate symbol, mark the areas of the body where you feel the described sensation. Include all of the affected areas and be as accurate as possible. Mark a range if appropriate.

Pins, needles, numbness	OOO
Burning	XXX
Stabbing	/ / /
Aching	= = =



2) Rate your pain intensity by marking the scale below:

0- 10
No pain Worst possible

3) How often do you have symptoms?

25 50 75 100% of the time

-Continued on other side-

Medical History-Please note any past or current problems. Use "C" for current "P" for past.

__High blood pressure	__Depression	__HIV/AIDS	__Foot
__Diabetes	__ Digestive problem	__Drug/alcohol dependency	__Shoulder
__ Allergies	__Bowel disorders	__Bladder infections	__Arm/Hand
__ Respiratory Disorder	__Hearing loss	__Chronic sinus, flu, colds	__Eyes
__Heart disease	__Stroke	__ Headaches	__Arthritis
__Prostate	__Chronic fatigue	__Neck pain/stiffness	__Spinal curvature
__Fibromyalgia	__ Menopause	__ Lower back pain	__Jaw problems/TMJ
__ Menstrual problems	__ Cancer	__Knee	__Weight loss or gain

Other/explain any of above: _____ _____

Please check any of the following that apply to you:

☐ Pregnant (Due date_____)

☐ Pacemaker

☐ Accidental injuries _____

☐ Surgeries (and dates) _____

☐ Current medications _____

_____

☐ Vitamin supplements _____

☐Tobacco use: ☐ Never ☐Prior smoker ☐ Alcohol: (drinks per day _____)

☐Current:____packs/day

Family history: Please mark if your <u>parents</u> or <u>siblings</u> have had:

☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Alzheimer's/dementia

Insurance Information

Insured's Name _____ DOB:_____

Insurance Co._____ Employer_____

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 to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 services rendered to me will be immediately due and payable.

This information provided by me is to the best of my knowledge complete and accurate. I authorize release of any medical information necessary to process insurance claims.
I authorize payment of medical benefits by my insurance company directly to Langholff Chiropractic and Wellness.

Patient's or guardian signature_____Date_____

*Thank you- A complete understanding of your health status will help us help **you**!*