Confidential Patient Case History

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

Date_____ Name_____

Address_____ Zip_____

Phone_____ Cell Phone # _____S.S. #_____

Age_____Date of Birth _____ Sex M F Occupation _____

Employer _____ Work Phone_____

Marital Status S M W D No. of Children____Spouse's Name _____Cell Phone #_____

Employer_____ Work Phone_____

Have you been to a Chiropractor before? Y N Doctor_____

Date of last visit _____

How did you find out about our office? _____

Will we be processing insurance for you? Yes No Type of Insurance: ☐ Accident ☐ Auto ☐ Medicare

If yes, please state name of insurance company _____

Policy Number_____

Insurance Company Address _____

Medicare Supplement _____ ☐ Group ☐ Individual ☐ Worker's Compensation

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Please check the appropriate boxes for the following symptoms. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

C - CURRENTLY P - PREVIOUSLY N - NEVER

GENERAL SYMPTOMS

C	P	N	
☐	☐	☐	Headache
☐	☐	☐	Fever
☐	☐	☐	Chills
☐	☐	☐	Night Sweats
☐	☐	☐	Fainting
☐	☐	☐	Dizziness
☐	☐	☐	Convulsions
☐	☐	☐	Loss of Sleep
☐	☐	☐	Fatigue
☐	☐	☐	Nervousness
☐	☐	☐	Loss of Weight
☐	☐	☐	Numbness or Pain in arms/legs/hands
☐	☐	☐	Wheezing

MUSCLE & JOINTS

☐	☐	☐	Weakness
☐	☐	☐	Twitching
☐	☐	☐	Stiff Neck
☐	☐	☐	Backache
☐	☐	☐	Swollen Joints
☐	☐	☐	Tremors
☐	☐	☐	Foot Trouble
☐	☐	☐	Painful Tail Bone
☐	☐	☐	Pain Between Shoulders
☐	☐	☐	Hernia
☐	☐	☐	Spinal Curvature

HABITS

C	P	N	
☐	☐	☐	Smoking__ pks/day
☐	☐	☐	Drinking Alcohol
☐	☐	☐	Coffee__ cups/day

GASTRO-INTESTINAL

☐	☐	☐	Poor Appetite
☐	☐	☐	Poor Digestion
☐	☐	☐	Excessive Hunger
☐	☐	☐	Belching or Gas
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting Blood
☐	☐	☐	Pain Over Stomach
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Colon Trouble
☐	☐	☐	Hemorrhoids (Piles)
☐	☐	☐	Liver Trouble
☐	☐	☐	Jaundice
☐	☐	☐	Gall Bladder Trouble

CARDIO-VASCULAR

☐	☐	☐	Rapid Heart
☐	☐	☐	Slow Heart
☐	☐	☐	High Blood Pressure
☐	☐	☐	Low Blood Pressure
☐	☐	☐	**Pace Maker**
☐	☐	☐	Pain Over Heart
☐	☐	☐	Prev. Heart Trouble
☐	☐	☐	Swelling of Ankles
☐	☐	☐	Poor Circulation
☐	☐	☐	Varicose Veins
☐	☐	☐	Strokes
☐	☐	☐	Exercise

EYE-EAR-NOSE-THROAT

☐	☐	☐	Poor Vision
☐	☐	☐	Crossed Eyes
☐	☐	☐	Pain in Eyes
☐	☐	☐	Deafness
☐	☐	☐	Earache
☐	☐	☐	Ear Noises
☐	☐	☐	Ear Discharges
☐	☐	☐	Nasal Obstruction
☐	☐	☐	Nose Bleeds
☐	☐	☐	Sore Throat
☐	☐	☐	Hoarseness
☐	☐	☐	Hay Fever
☐	☐	☐	Asthma
☐	☐	☐	Frequent Colds
☐	☐	☐	Enlarged Thyroid
☐	☐	☐	Tonsillitis
☐	☐	☐	Sinus Trouble

SKIN OR ALLERGIES

☐	☐	☐	Skin Eruptions
☐	☐	☐	Itching
☐	☐	☐	Bruising Easily
☐	☐	☐	Dryness
☐	☐	☐	Boils
☐	☐	☐	Sensitive Skin
☐	☐	☐	Hives or Allergy
☐	☐	☐	Eczema

RESPIRATORY

☐	☐	☐	Chronic Cough
☐	☐	☐	Spitting Blood
☐	☐	☐	Spitting Phlegm
☐	☐	☐	Chest Pain
☐	☐	☐	Difficulty Breathing

GENITO-URINARY

☐	☐	☐	Frequent Urination
☐	☐	☐	Painful Urination
☐	☐	☐	Blood in Urine
☐	☐	☐	Kidney Infection
☐	☐	☐	Bed Wetting
☐	☐	☐	Inability to Control Urine
☐	☐	☐	Prostate Trouble

FOR WOMEN ONLY

☐	☐	☐	Painful Periods
☐	☐	☐	Excessive Flow
☐	☐	☐	Irregular Cycles
☐	☐	☐	Hot Flashes
☐	☐	☐	Cramps or Backache
☐	☐	☐	Miscarriage
☐	☐	☐	Vaginal Discharge
☐	☐	☐	Pregnant at this time
☐	☐	☐	Last Pap

By Whom_____

Other_____

_____

Are you currently being treated for any conditions through another physician? If yes, please explain:

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

___ Appendicitis	___ Anemia	___ Heart Disease	___ Arthritis
___ Pneumonia	___ Measles	___ Goiter	___ Epilepsy
___ Rheumatic Fever	___ Mumps	___ Influenza	___ Mental Disorder
___ Polio	___ Chicken Pox	___ Pleurisy	___ Lumbago
___ Tuberculosis	___ Diabetes	___ Alcoholism	___ Eczema
___ Whooping Cough	___ Cancer	___ Venereal Disease	

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
No. of__ Sister	☐	☐	☐	☐	☐
No. of__					

IMPORTANT

TO THE PATIENT: Please list below the five or more main complaints you have in the order of importance. Also the length of time you have had this complaint.

1._____How Long?_____
2._____How Long?_____
3._____How Long?_____
4._____How Long?_____
5._____How Long?_____

List other Doctors seen for this condition, their diagnosis and treatment_____

_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is the condition interfering with your: ☐ Work ☐ Sleep ☐ Daily ☐ Routine ☐ Other _____

How long has it been since you really felt good?_____

What do you believe is wrong with you? _____

List Surgical operations and years: _____

_____

Any recent injuries, falls, or accidents?_____

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills ☐ Tranquilizers ☐ Birth Control Pills ☐ Others_____

Are you wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

Have you been in an auto accident: ☐ Past Year ☐ Past Five Years ☐ Over Five Years ☐ Never

Describe:_____

In case of emergency, please provide two names and phone numbers of either nearest relatives or friends _____

_____

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for other than surgery?	☐	☐	_____
DO YOU:			
Take vitamins or minerals?	☐	☐	_____
Have an allergy to any drug?	☐	☐	_____

DATE OF LAST:	Less than 6 mos.	6-18 mos.	Over 18 mos.	Never
Spinal examination:	☐	☐	☐	☐
Physical examination:	☐	☐	☐	☐
Blood test:	☐	☐	☐	☐
Chest X-ray:	☐	☐	☐	☐
Spinal X-ray:	☐	☐	☐	☐
Dental X-ray:	☐	☐	☐	☐
Urine Test:	☐	☐	☐	☐

Please indicate if your condition is a result of: ☐ Illness ☐ On-the-Job Injury ☐ Auto Accident ☐ Home Injury ☐ Other

Please check the type of care desired so that we may be guided by your wishes when possible:

☐ Temporary Relief ☐ Control of Immediate Pain ☐ Total Health Care

☐ I prefer the doctor select the type of care he feels is best for me.

"I understand and agree that the above information is correct as stated."

Today's Date_____ Patient's Signature _____

Thank you for choosing Rushin Chiropractic Center for your healthcare needs. Rest assured that every effort will be made to relieve your condition as soon as possible. Our primary goal is helping your body regain and maintain health, and we want to help you obtain that goal as quickly and economically as possible.

Rushin Chiropractic Center
Jack D. Rushin, D.C.