CASE HISTORY

FULL NAME:_____ DATE:_____ CHART#:_____

HISTORY OF PRESENT INJURY/ILLNESS(the reason for your visit today)
Please list below the complaint(s) you have in the order of importance. Also , please list the length of time this (or these) complaint(s).

1._____ How long?_____
2._____ How long?_____
3._____ How long?_____
4._____ How long?_____

Is your condition(s) related to an accident? ☐ Yes ☐ No
Date of accident:_____ Type of accident: ☐ Auto ☐ Work Related ☐ Other:_____
What word best describes your present condition(s)? ☐ Dull Ache ☐ Sharp/Stabbing ☐ Burning/Tingling _____
Circle the number that matches your level of pain at its worst (0 = no pain, 10 = most severe)

0 1 2 3 4 5 6 7 8 9 10

When is your condition most severe? (am/pm) _____
When is your condition least severe? (am/pm) _____
What makes your condition feel worse? _____
What makes your condition feel better? _____
What activities are difficult because of your condition(s)? _____
Have you seen any other healthcare provider for your present condition? ☐ Yes ☐ No Who? _____
Current Medications _____
Who is your family physician? _____
Are you, or could you be pregnant? ☐ Yes ☐ No Date of last menstrual cycle? _____
Are you experiencing or do you have any of the following?

☐ A sore that won't heal	☐ Difficulty swallowing	☐ Persistent cough/hoarseness
☐ Wart or mole changes	☐ Lump/thickening anywhere	☐ Weight loss without trying
☐ Bladder/bowel problems	☐ Night pain	☐ **None of the above**

REVIEW OF SYSTEMS
In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?

NEUROMUSCULOSKELETAL SYSTEM

☐ Anxiety	☐ Facial drooping	☐ Memory loss	☐ Sensory changes
☐ Atrophy	☐ Headache	☐ Mood swings	☐ Speech problems
☐ Concussion	☐ Joint deformity	☐ Muscle weakness	☐ Stiffness
☐ Depression	☐ Joint swelling	☐ Numbness	☐ Tremors
☐ Difficulty walking	☐ Lack of coordination	☐ Popping noises	☐ Twitches
☐ Dizziness	☐ Limited range of motion	☐ Psychiatric disorders	☐ Vision trouble
☐ Extremity deformity	☐ Loss of balance	☐ Seizures	☐ **None of above**

CARDIOVASCULAR SYSTEM

☐ Ankle swelling	☐ Chest Pain	☐ Known vascular disease	☐ Previous stroke
☐ Blood clots	☐ Dizziness/Fainting	☐ Mitral valve prolapse	☐ Shortness of breath
☐ Carotid blockage	☐ High blood pressure	☐ Phlebitis	☐ Varicose veins
☐ Changes in skin color	☐ Jaw pain	☐ Pin stroke	☐ **None of above**

PAST HISTORY/FAMILY HISTORY
List any surgeries you have had (including appendix, tonsils, wisdom teeth)

1._____ Date _____ 3._____ Date _____
2._____ Date _____ 4._____ Date _____

Have you ever been hospitalized for anything in addition to surgery (broken bones, etc.)? ☐ Yes ☐ No
If yes, what and when? _____
Have you or a family member ever been diagnosed with diabetes, heart trouble or cancer? ☐ Yes ☐ No
If yes, who and what? _____
Are you currently under a doctor's care for condition(s) other than the ones you are seeking here? ☐ Yes ☐ No
If yes, for what with whom?_____

CONFIDENTIAL PATIENT INFORMATION

FULL NAME:_____ Birth Date:_____ Gender: ☐Male ☐Female

Parent's/Guardian Name: (if patient is a minor):_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ Email Address:_____ SS#:_____

Marital Status: S M W D SEP Spouse Name:_____ Birth Date:_____

Your Employer:_____ Occupation:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Spouse's Employer:_____ Spouse's Occupation:_____

Primary Insurance:_____ Secondary Insurance:_____

(Please allow our staff to photocopy your current health insurance card(s) and your driver's license)

HEALTH HABITS

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK/SCHOOL ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

PERSONAL HABITS

- ☐ Smoking
- ☐ Alcohol
- ☐ Coffee/Caffeine
- ☐ Vitamins

HOBBIES / ACTIVITIES

What are your favorite hobbies and activities?_____

How are your current problem(s) affecting these hobbies or activities?_____

HOW DO YOU WANT TO HANDLES YOUR PROBLEM?

☐Temporary relief (help the symptoms but not fix the problem)

☐Maximum correction (correct the cause of the problem for maximum stability in the future)

REFERRED BY:_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to PHOENIX CHIROPRACTIC INJURY CLINIC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician.

I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. I hereby waive the statute of limitations on collection and recovery in this State of Arizona. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE OF INSURED/GUARDIAN:_____ DATE: _____