BUTLER CHIROPRACTIC REHAB CENTER, INC

Case #: _____ **Date:** _____

PERSONAL INFORMATION

Full Name_____ Nickname_____

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

Occupation_____ Email:_____

Sex: M F Marital Status: S M D W Age:____ Birthday: _____/_____/_____ SS#_____

How did you hear about our clinic?_____

Name of person responsible for account_____ Method of Payment_____

Emergency Contact Name_____ Phone ( )_____

PRESENT COMPLAINT

Briefly describe symptoms:_____

_____

_____

Other doctors seen for this condition:_____ Treatment rendered_____

Are you taking any medication? YES NO What kind?_____

List physicians seen within the year… For what condition(s)

_____ _____

_____ _____

_____ _____

INSURANCE INFORMATION

Relationship to insured: ☐Self ☐Spouse ☐Child ☐Other
If insured is self, complete any information not listed above.
If insured is someone other than you, please complete **all** information below:

Insured's Full Name_____ Insured's Date of Birth _____/_____/_____

Address_____ City_____ State_____ Zip_____

Home Phone( )_____ SS#_____

Attorney Name:(If accident related)_____ Phone( )_____

Insurance Company_____ Phone( )_____

Insured's ID#_____ Group#:_____

Employed by_____ Phone( )_____

Address_____ City_____ State_____ Zip_____

Additional Insurance Company_____ Phone( )_____

Relationship to insured: ☐Self ☐Spouse ☐Child ☐other

Insured's Full Name_____ Insured's Date of Birth_____/_____/_____

Insured's SS#_____ ID#_____ Group#_____

COMPREHENSIVE HISTORY

Name_____ Case#_____ Date_____

PAST HISTORY

Check any of the following diseases you have had:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Epilepsy	☐ Eczema
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Mental Disorder	☐ HIV/AIDS
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Anemia	☐ Multiple Sclerosis
☐ Tuberculosis	☐ Measles	☐ Diabetes	☐ Lumbago	☐ Parkinson's
☐ Whooping Cough	☐ Cancer	☐ Heart Disease	☐ Venereal Disease	☐ Thyroid

List any surgeries_____

_____

List any broken bones/dislocations_____

_____

Have you ever been in an automobile accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Have you ever had any spinal taps/injections? ☐ Y ☐ N

PRESENT HISTORY

Check any of the following you have had in the past 6 months:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Pain Between Shoulders
- ☐ Joint Pain/Stiffnes
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ General Stiffness

NERVOUS SYSTEM

- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall BLadder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramping
- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Discolored Urine
- ☐ Painful/Excessive Urination

CARDIO-VASCULAR

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE / FEMALE

- ☐ Vaginal Pain
- ☐ Vaginal Infection
- ☐ Prostate Problems
- ☐ Breast Lumps
- ☐ Breast Pain/Lumps
- ☐ Sexual Dysfunction

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Eating Problems
- ☐ Sleeping Problems
- ☐ Fever
- ☐ Headaches
- ☐ Difficulty Lifting
- ☐ Difficulty Standing
- ☐ Difficulty Sitting
- ☐ Difficulty Walking
- ☐ Difficulty Bending

Women Only: Menstrual History

Date of last period_____ Age at onset_____ Are your periods regular? ☐ Y ☐ N

If not, explain:_____

Are you currently using birth control? ☐ Y ☐ N If so, What?_____

Are you currently pregnant? ☐ Y ☐ N Number of pregnancies_____ Number of deliveries_____

Social History

Do you drink caffeinated beverages? ☐ Y ☐ N What Kind?_____ Cups/Day_____

Do you smoke? ☐ Y ☐ N How many per day?_____ Since when?_____

Do you use other tobacco products? ☐ Y ☐ N What?_____

Do you consume alcohol? ☐ Y ☐ N How many drinks per week?_____

Has your vision changed lately? ☐ Y ☐ N How?_____

How is your sleep?_____ Average # hours/night_____

Do you wear heel lifts or other foot supports? ☐ Y ☐ N Explain_____

Do you exercise? ☐ Y ☐ N Explain_____

Family Stress: ☐ Severe ☐ Moderate ☐ Minimal Work Stress: ☐ Severe ☐ Moderate ☐ Minimal

Family Health History

☐ Asthma	☐ Tuberculosis	☐ Kidney Disease	☐ Musculoskeletal Disease
☐ Diabetes	☐ Emphysema	☐ Epilepsy	☐ Headaches
☐ Heart Disease	☐ Insomnia	☐ Cancer	☐ High Blood Pressure
☐ Scoliosis	☐ Sinus Trouble	☐ Stomach Trouble	☐ Nervousness
☐ Low Back Pain	☐ Disc Problems	☐ Thyroid Disease	☐ Other (list below)

Comments:_____

_____

Please read below and sign. Thank you!

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 and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. Patient balances remaining after 90 days will be subject to a 1.5% (18% APR) monthly interest charge.

Patient's Signature_____ SS#_____ Date_____

Guardian or Spouse's
Signature Authorizing Care_____ Date_____

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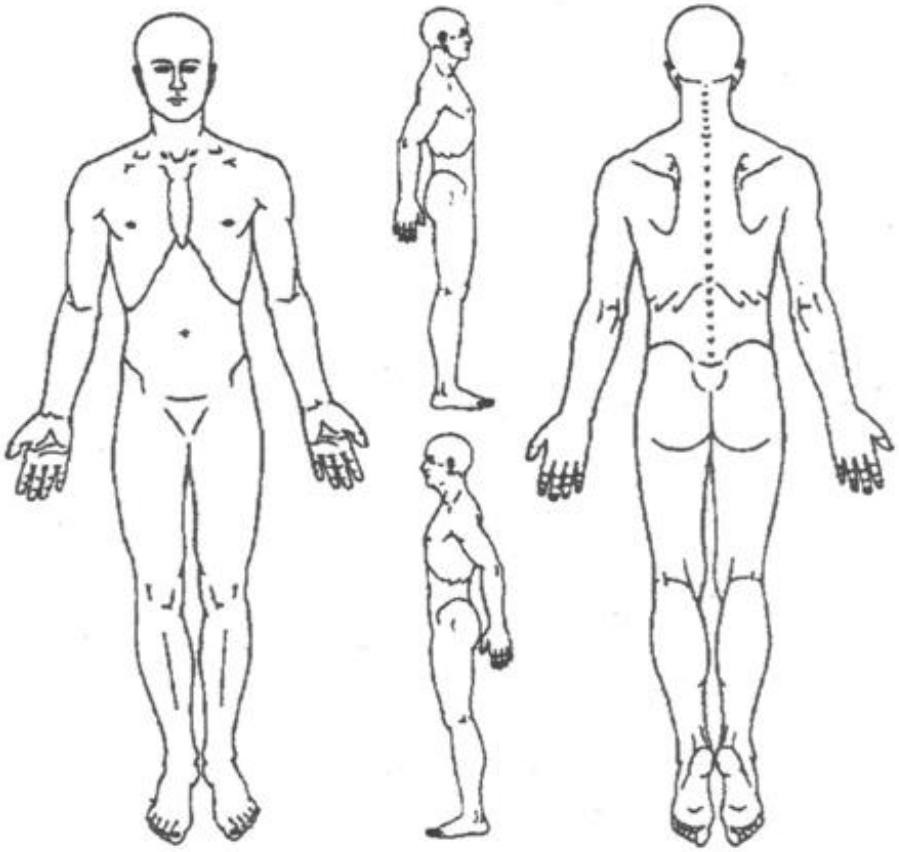
Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Please use the space below to describe your condition further if needed:

_____

_____

_____

Date: _____ Signature: _____