De Bruin Chiropractic, Ltd

CONFIDENTIAL PATIENT CASE HISTORY

Today's Date / / Signature of Patient _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ Nick Name_____

Last Name _____ Middle Name _____Suffix _____

Address 1 _____

City_____ State_____ Zip Code _____

Primary Phone _____Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Occupation _____ Employer _____

Who may we thank for referring you? _____

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / Age _____ Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other SSN _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

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Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1)_____ 3) _____
2) _____ 4) _____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Please list complaints and the approximate dates the conditions began. Please start with your most important concerns.

Complaints **Date Started**

1:_____

2:_____

3:_____

4:_____

5:_____

Is your condition the result of an accident? ❑ Yes ❑ No If yes, was it a ❑ Motor Vehicle Accident or ❑ Work Injury?Is your situation getting worse? ❑ Yes ❑ No Have you seen others doctors for your condition? ❑ Yes ❑ NoPlease list other doctors you have seen and the approximate dates you saw them.

Doctors **Date**

1: _____

2: _____

3: _____

May Dr. De Bruin inform your primary care doctor and/or specialists of you condition and treatment? ❑ Yes ❑ No

Please list any surgical procedures you have had and the approximate date.

Surgical Procedures **Date**

1: _____

2: _____

3: _____

4: _____

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Please check any condition that any blood relative has ever had:

◊ Cancer ◊ High Blood Pressure ◊ Heart Disease ◊ Diabetes ◊ Stroke ◊ Arteriosclerosis

Please check any conditions you have now or that you have had in the past:

◊ Alcoholism ◊ Cancer ◊ Gout ◊ Migraine Headaches ◊ Pneumonia ◊ Stroke ◊ Anemia
◊ Diabetes ◊ Heart Disease ◊ Miscarriage ◊ Psoriasis ◊ Tuberculosis ◊ Arterial Disease
◊ Emphysema ◊ Hepatitis ◊ Multiple Sclerosis ◊ Rheumatic Fever ◊ Ulcers
◊ Arthritis ◊ Epilepsy ◊ HIV Positive ◊ Parkinson's ◊ Rheumatoid Arthritis ◊ Asthma
◊ Goiter ◊ Measles ◊ Polio ◊ Scoliosis

Please check the following symptoms you have now or have had repeatedly in the past year:

General
◊ Allergy
◊ Chills
◊ Convulsions
◊ Depression
◊ Dizziness
◊ Fainting
◊ Fatigue
◊ Fever
◊ Headache
◊ Insomnia
◊ Sweats
◊ Weight loss

Cardiovascular
◊ Chest pain
◊ High blood pressure
◊ Low blood pressure
◊ Rapid heart beat
◊ Slow heart beat

Muscle & Joint
◊ Foot trouble
◊ Hernia
◊ Low back pain
◊ Neck pain
◊ Sciatica
◊ Swollen joints
◊ Upper back pain

Pain or Numbness In:
◊ Shoulders
◊ Arms
◊ Elbows
◊ Hands
◊ Hips
◊ Legs
◊ Knees
◊ Feet
◊ Tail bone

Eyes, Ears, Nose & Throat
◊ Earache
◊ Ear discharge
◊ Enlarged glands
◊ Enlarged thyroid
◊ Eye pain
◊ Visual problems
◊ Hoarseness
◊ Nasal Obstruction
◊ Nosebleeds
◊ Ringing in ears
◊ Sinus infection
◊ Sore throat

Respiratory
◊ Chronic cough
◊ Difficult breathing
◊ Spitting up blood
◊ wheezing

Gastrointestinal
◊ Heartburn
◊ Colitis
◊ Colon trouble
◊ Constipation
◊ Diarrhea
◊ Digestive problems
◊ Gall bladder pain
◊ Hemorrhoids
◊ Jaundice
◊ Liver trouble
◊ Nausea
◊ Stomach pain
◊ Poor appetite
◊ Vomiting
◊ Vomiting blood
◊ Rectal pain

Skin
◊ Bruise easily
◊ Hives
◊ Itching
◊ Rashes
◊ Varicose veins

Urinary
◊ Bed wetting
◊ Blood in urine
◊ Frequent urination
◊ Painful urination
◊ Bladder control
◊ Kidney stones
◊ Prostate trouble

For Women Only:
◊ Hot flashes
◊ Irregular cycle
◊ Menstrual pain
◊ Menopausal

Have you been knocked unconscious? ❑ Yes ❑ No Have you had a blood transfusion? ❑ Yes ❑ No
Have you tested positive for HIV? ❑ Yes ❑ No Tested positive for Hepatitis C? ❑ Yes ❑ No
Do you drink alcohol? ❑Yes ❑No If yes, how many drinks per week? _____.

Are you pregnant? ❑Yes ❑No When was the first day of your last menstrual period? _____
By my signature, I, _____ do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Patient's Signature: _____ Date _____

I hereby affirm that the above information is complete and accurate to the best of my knowledge. Furthermore, I hereby consent to any necessary and reasonable treatment for the conditions(s) for which I have sought treatment. I also understand that I have the right and duty to ask my doctor to explain further anything in connection with my condition, care, or treatment that I do not understand.

Patient's Signature: _____ Date _____

I hereby affirm that I am the appropriate individual to authorize care on behalf of _____ and that I hereby agree to the above on his/her behalf.

Guardian or Spouse's
Signature Authorizing Care _____ Date _____