

Spine Care Associates of Alexandria, Inc.
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Date _____

NEW PATIENT CASE HISTORY:

Name: _____ DOB: _____ Age _____
Address: _____ SS# _____
City: _____ State: _____ Zip: _____ Single/Married/Divorced
Hm. # _____ Wk.# _____ Cell.# _____
Emergency Contact: Name _____ # _____
Employer: _____ Occupation: _____
Referred By: Internet/ Phonebook/ Insurance/ Coupon/ Other/ Patient _____
Primary Care Phy. _____ ph.# _____
Would you like a letter sent to your Primary Care Physician? Y / N
Email: _____
Previous Chiropractic Care? Y/N If so how long ago? _____

MAIN COMPLAINT:

Why are you here today?(Please be specific) _____

1. When did it start? _____ 2. How did it start? _____
3. Work related? Y/N , Auto Accident? Y/N , Other Accident? Y/N
4. Does the pain radiate to any other part of your body , if so where? _____
5. Did your pain begin **Gradually**, or **Suddenly**? (Circle one)
6. Is your pain **Mild**, **Moderate**, or **Severe**? (Circle one)
7. Is your pain? Circle all that apply: **Dull**, **Sharp**, **Burning**, **Numbness**, **Soreness**, **Stiffness**.
8. Has your problem been getting **Better**, **Worse** or the **Same**?
9. Is your pain **Intermittent**, or **Constant**?
10. What makes your symptom **Better**? _____ **Worse**? _____
11. Have you tried home remedies? _____
12. Have you seen any other doctors for this? _____
13. Have you had this before? Y/N If so when? _____
14. Any changes in body function? **Explain** _____
15. Have you lost any work as a result of your current problem? Y/N How Long? _____
16. Do you have any other problem you would like the Dr. To evaluate? _____

INSURANCE:

Name of Insurance: _____ Policy Holder: _____ DOB: _____
Policy # _____ Grp# _____ Employer: _____
Signature of Patient or Guardian: _____ (assign of benefits)

PAST MEDICAL HISTORY

- 1. Have you had any of the follow childhood diseases? **Measles, Rubella, Chicken Pox, Mumps, Scarlet Fever, Rheumatic Fever, Tuberculosis, Other:** _____
- 2. Have you been diagnosed with any other conditions? _____
- 3. Are you under a doctors care for any condition? **Y/N** _____
- 4. Have you ever broken any bones? **Y/N** _____
- 5. Have you had any past significant auto accidents? **Y/N** When? _____
- 6. Please list any current medications you are taking. _____
- 7. Have you under gone any surgeries? **Y/N** Explain. _____
- 8. Do you drink, smoke or use any recreational drugs? Explain. _____
- 9. Do you have any allergies? **Y/N** Explain. _____
- 10. History of family diseases? Explain. _____

Have you ever been diagnosed with any of the following? Please Circle Yes or No.

- Y/N** High Blood Pressure **Y/N** Hardening of the arteries
- Y/N** Diabetes **Y/N** Heart or blood vessel diseases
- Y/N** Bone spurs on neck **Y/N** Whiplash injury
- Y/N** Blurred or Double Vision **Y/N** Relatives who have suffered strokes
- Y/N** Currently Smoke **Y/N** Smoked in the past

Have you had any of the symptoms in the past **Year**?

- Y/N** Slurred speech or speec Problems **Y/N** Difficulty swallowing
- Y/N** Dizziness **Y/N** Temporary lack of understanding
- Y/N** Loss of consciousness, or Black out **Y/N** Numbess in face, arms, hands fingers, or legs
- Y/N** Any other abnormal loss of sensation **Y/N** Diminished or partial loss of vision
- Y/N** Weakness, Clumsiness or strength loss **Y/N** Hearing loss in one or both ears
Face, arms, hands, fingers, or legs

Men Only:

Date of last prostate exam: _____ Difficulty urinating? **Y/N** Frequent Urination? **Y/N**

Women Only:

Are you currently taking Birth control pills? **Y/N** If yes how long? _____
Y/N Menstrual Pain **Y/N** Cramps **Y/N** Irregularity **Y/N** Pregnant? How long? _____

Signature of Consent to Treatment: _____

If Minor Child: Name: _____ Relationship _____

Witness: _____ Date: _____