CASE HISTORY

Name:_____ Social Security #:_____ Date:_____

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

Home Phone:_____ Alternate Phone:_____ Email:_____

DOB:_____ Age:_____ Marital Status: M S W D Spouses Name:_____

Number of Children:_____ Occupation:_____ Employer:_____

In Case of Emergency Contact:_____ Phone:_____

If you were referred, by whom?_____

When doctors work together it benefits you. May we have your permission to update your medical doctor

regarding your care at this office? Yes___ No___ Doctor's Name:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Borck Family Chiropractic P.C. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow Borck Family Chiropractic P.C. to use their Patient Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know you your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief complaint:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work___ Other_____

Have you ever had the same or similar condition? Yes___ No___ If yes, when and describe_____

_____

Days lost from work:_____ Date of last physical examination:_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Yes___ No___ Women, please include information about childbirth (include dates):_____

_____

Have you been treated for any health condition by a physician in the last year? Yes___ No___ If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? Yes___ No___ If yes, describe:_____

_____

Do you have any allergies of any kind? Yes___ No___ If yes, describe:_____

_____

Women: Are you pregnant? Yes___ No___

Estimated Height:_____ Estimated Weight:_____ BP_____/_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches___Frequency_____
Stiff Neck___
Neck Pain___
Back Pain___
Shoulder/Neck/Arm Pain___
Numbness in Fingers___
Numbness in Toes___
Muscle Spasms___
Weakness in Extremities___
Ears Ring___
Buzzing in Ears___
Feet Cold___
Hands Cold___
Loss of Balance___
Sleeping Problems___

Dizziness___
Fainting___
Tension___
Irritability___
Nervousness___
High Blood Pressure___
Low Blood Pressure___
Chest Pains/Tightness___
Pacemaker___
Heart Disease___
Hypertension___
Circulation Problems___
Arthritis___
Rheumatoid Arthritis___
Osteoarthritis___

Joint Pain/Swelling___
Osteoporosis___
Broken Bones/Fractures___
Seizures/Epilepsy___
Stroke___
Cancer___
Breathing Problems___
Sinus Problems___
Frequent Colds___
Fever___
Fatigue___
Weight Loss/Gain___
Eating Disorder___
Depression___
Lights Bother Eyes___

Loss of Smell___
Loss of Taste___
Loss of Memory___
Coughing Blood___
Excessive Bleeding___
Ulcers___
Indigestion Problems___
Difficulty Urinating___
Unusual Bowel Patterns___
Gall Bladder Problems___
Diabetes___
Menstrual Difficulties___

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it: O = OFTEN S = SOMETIMES N = NEVER

_____Vigorous Exercise
_____Moderate Exercise
_____Alcohol Use
_____Drug Use
_____Tobacco Use_____Frequency/day
_____Caffeine
_____High Stress Activity
_____Family Pressures
_____Financial Pressures
_____Other Mental Stresses
_____Other (specify)_____
_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER AGE [ ]	MOTHER AGE [ ]	SPOUSE AGE [ ]	CHILDREN AGE [ ] AGE[ ] AGE [ ]
Arthritis				
Asthma-Hay Fever				
Sinus Trouble				
Headaches				
Migraine				
Cancer				
High Blood Pressure				
Nervousness				
Back Trouble				
Pinched Nerve				
Scoliosis				
Other:				

If any of the above family members are deceased, please list their age at death and cause:

_____

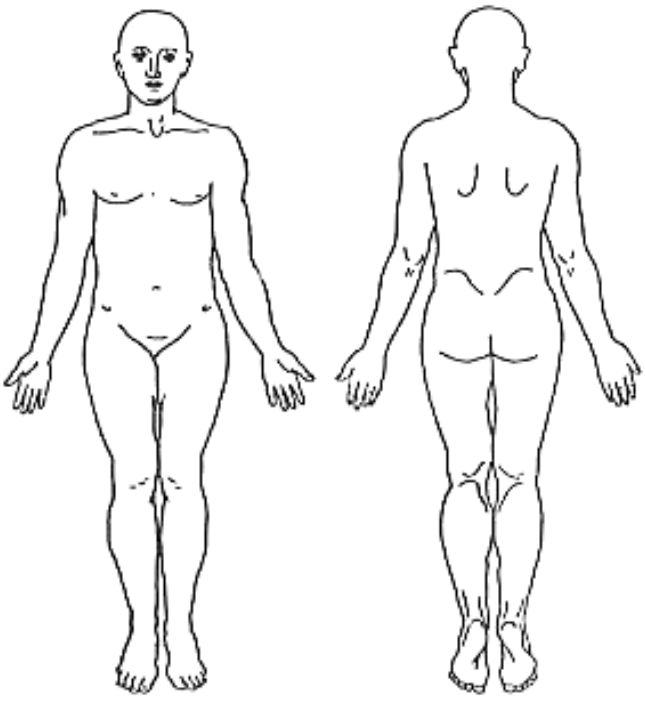
_____

I certify the above information provided is accurate to the best of my knowledge:

Name of Patient_____ Date_____

Signature of Patient/Legal Guardian_____

In the diagram below, please mark an "X" wherever you are having pain. Also indicate the type as well.



A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins & Needles
T=Throbbing

Example: XST between your shoulder blades means you have stabbing pain between your shoulders.

PAIN SCALE: Please circle the number that best describes your overall pain level:

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE

_____ _____