PATIENT CASE HISTORY

Name: ________________________________ Gender: M / F Spouse:____________________ # of children:_________

Address: _______________________________ City: ___________________________ State: ______ Zip: _____________

Home Phone: ______________________Work Phone: _____________________ Cell Phone: _______________________

Email Address: _____________________________ Occupation: ____

Emergency Contact: _______________________ Relationship:___________________ Phone: ______________________

Date of Birth: _____/_____/_____ Preferred Language:______________ Referred by: _______________________________

Height: _______ Weight: _______ Tobacco Use: Type/frequency_________________

List **ALL** **Past Medical History** conditions: ☐ **None**

☐ Cancer
☐ Dizziness/Fainting
☐ Eye/Vision Problems
☐ High Blood Pressure
☐ Osteoporosis
☐ Currently Pregnant: ___# of weeks
☐ Menstrual Problems
☐ Prostate Problems
☐ Spinal Cord Injury
☐ Recent Fever
☐ Taking Birth Control Pills
☐ Diabetes
☐ Epilepsy
☐ Pain unrelieved by position or rest
☐ numbness in groin/buttocks
☐ Urinary Problems
☐ Marked morning pain/Stiffness
☐ Pain at Night
☐ Significant Weight Change
☐ Stroke
☐ Corticosteroid use (cortisone/Predisone)

☐ Surgeries: _____________________________________ ☐ Other Health Problems: ______________________________________

☐ Medication: ____

List your **Family History**: Please answer the following questions with the following below or ☐ **None**

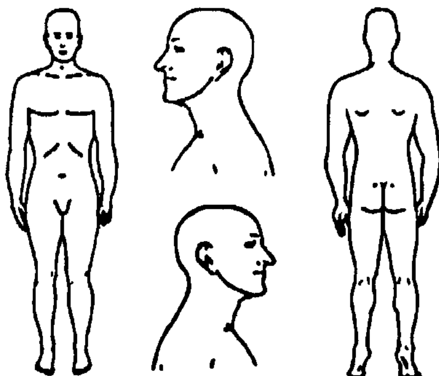
__ Cancer __ Diabetes __ High Blood Pressure __ Heart Problems/Stroke __Neurological Condition __ Rheumatoid Arthritis

Have you had any auto or other accidents? ☐ No ☐ Yes

Describe: ____

Date of last physical examination: _________________

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Have you ever had chiropractic care? ☐ No ☐ yes

When? ____________Why? __________________

Where? ____________________________________

Were X-rays taken? ☐ No ☐ Yes

When was your last adjustment? _______________

1. Describe your **MAJOR** complaint? ____Date problem began? ____________________

2. How did this problem begin? _______________________________________Have you had this condition in the past? ☐ YES ☐ NO

4. How often do you experience your symptoms? ☐ 76-100% **(Constant)** ☐ 51-75% ☐ 26-50% ☐ 0-25% **(Occasional)**

5. Describe the nature of your symptoms: ____

6. Do your symptoms radiate? ☐ YES ☐ NO If yes, where?____

7. Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

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

8. What activities aggravate your condition (working, exercise, etc)? ____

9. What makes your pain better (ice, heat, massage, etc)? ____

10. Is your condition getting better, worse or staying the same?____

1. Describe your **SECOND** complaint? ____Date problem began? ____________________

2. How did this problem begin? _______________________________________Have you had this condition in the past? ☐ YES ☐ NO

4. How often do you experience your symptoms? ☐ 76-100% **(Constant)** ☐ 51-75% ☐ 26-50% ☐ 0-25% **(Occasional)**

5. Describe the nature of your symptoms: ____

6. Do your symptoms radiate? ☐ YES ☐ NO If yes, where?____

7. Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

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

8. What activities aggravate your condition (working, exercise, etc)? ____

9. What makes your pain better (ice, heat, massage, etc)? ____

10. Is your condition getting better, worse or staying the same?____

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms

☐ RELIEF CARE: Symptomatic relief of pain or discomfort

☐ I want the Doctor to select the type of care appropriate for my condition

ASSIGNMENT & RELEASE

Please Initial:

_____I understand that a HIPAA informative brochure is available to read in the office and it will inform me of my privacy rights.
_____I certify that to the best of my knowledge I am not pregnant and give the doctor permission to perform an x-ray evaluation in necessary.
_____I give consent to the doctor to evaluate and adjust my minor
_____I understand I will be treated in an open room facility and other people in the room may overhear my conversation with the doctor regarding my medical condition/treatment and my financial information.
_____ I authorize release of information to family physicians if necessary
_____ I authorize release of information to insurance companies
_____ I authorize the taking of x-rays and/or photographs to be used for treatment purposes.
_____ I understand that writing a check without sufficient funds may be a crime under Cal. Civil Code section 1719. Understand and agree that if I have insufficient funds and my check bounces I will pay Nicholas Brock Chiropractic, Inc. an NSF fee of $35 in addition to my check amount.
_____ I authorize my insurance benefits to be paid directly to:

Nicholas Brock Chiropractic, Inc./ Nicholas Brock, D.C.1625 E. Thousand Oaks Blvd. Suite E. Thousand Oaks, CA 91362 (805)496-4469

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient’s Signature:_____________________________________ Date:_____________________