Alliance Chiropractic and Massage

Confidential Case History

How did you hear about us? ______________________________ Date: ______________________

Patient Information

Name: ____ ☐ Male ☐ Female

(First) (Initial) (Last) (Name Called by)

Address: __________________________City___________________ State _________Zip_____________

Date of birth: _____________________ Social Security #: _____/_____/_____

Occupation: _________________ ☐ Full Time ☐ Part Time ☐ Retired Employer:________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Spouses Name: ____________________

# of Children_____

Contact Information

Home Phone: _____________________ Cell Phone: ___________________ Work Phone: ________________

Email: ____________________________ Family Doctor: _______________ Last visit: __________________

Best way to contact you: ☐ Home phone ☐ Cell Phone ☐ Work Phone ☐ Email

In Case of Emergency—Contact Information

Name: ___________________________________ Relationship: ________________________________

Home Phone: ______________________________ Cell Phone: __________________________________

Patient Conditions

What is your major symptom/problem? __________________________

____

When did your symptoms begin? ____________________________

How did your symptoms begin? _____________________________

Have you had this problem before? ☐ Yes ☐ No

Is your condition getting worse? ☐ Yes ☐ No

Do your symptoms radiate into: ☐ Arms ☐ Legs ☐ None ☐ Other _________

Is this problem: ☐ Constant ☐ Comes & Goes

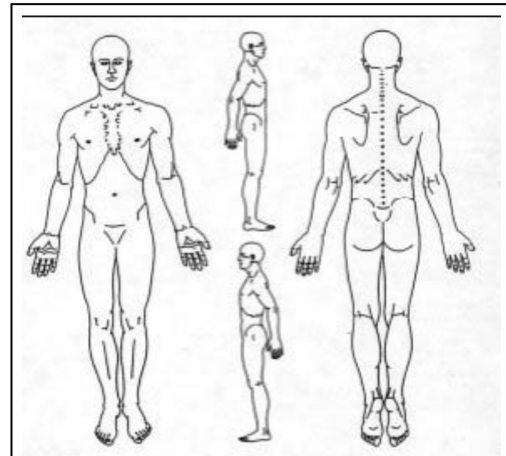
How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull

☐ Tingling ☐ Swelling ☐ Throbbing

☐ Other: ____

Circle the severity of the pain on a 0 to 10 scale:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)



Please mark where it hurts

What makes your condition better? ____

What makes your condition worse? ____

What other treatments have you had for this condition?____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/Movements that are painful to perform: ☐ Lying down ☐ Standing ☐ Walking ☐Sitting ☐ Bending ☐ Getting up ☐ Driving ☐ Reading

Have there been any changes in your bodily functions? ☐ Yes ☐ No (if yes, what?) ____________________________

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Medical History 2:

Surgical History: List any surgical procedures you have had:

Surgery Name: ________________ **Date Performed:** ________________
Surgery Name: ________________ **Date Performed:** ________________
Surgery Name: ________________ **Date Performed:** ________________
Surgery Name: ________________ **Date Performed:** ________________

Allergies: Environmental or Medical Allergies

Allergy Name: ________________ **Date Detected:** ________________
Allergy Name: ________________ **Date Detected:** ________________
Allergy Name: ________________ **Date Detected:** ________________
Allergy Name: ________________ **Date Detected:** ________________

Current Medications/Supplements

Rx Name: ________________ **Reason:** ________________
Rx Name: ________________ **Reason:** ________________
Rx Name: ________________ **Reason:** ________________
Rx Name: ________________ **Reason:** ________________

Accident History: Enter all auto accidents, slips & Falls, Sports or work related injuries that you had in the past.

Accident Type:	**Date:**	**Chiropractic Treatment Received**
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall	________	☐Yes ☐ No
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall	________	☐Yes ☐ No
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall	________	☐Yes ☐ No
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall	________	☐Yes ☐ No

Main Reason for consulting this office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

Females:

Are you pregnant? ☐ Yes ☐ No

Date of last menstrual cycle: ________________

Sleep positions:

☐ Back ☐ Side ☐ Stomach

Do you wear heel lifts?

☐ Yes ☐ No

Authorization

*Insurance verification and authorization are not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize **Alliance Chiropractic and Massage/Jeffrey Scott Ruth, D.C.** to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.*

________________ Signature

________________ Date

________________ Parent (if patient is a minor)

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Family History:	**Back**	**Heart**	**Stroke**	**Cancer**	**Diabetes**	**High Bp**
Mother:	☐	☐	☐	☐	☐	☐
Father:	☐	☐	☐	☐	☐	☐
No. of sisters: ____	☐	☐	☐	☐	☐	☐
No. of brothers: ____	☐	☐	☐	☐	☐	☐

Social History:

	Daily	**3x/wk**	**2x/wk**	**1x/wk**	**2x/mo**	**1x/mo**	**Never**
Tobacco/Smoke:	☐	☐	☐	☐	☐	☐	☐
Exercise:	☐	☐	☐	☐	☐	☐	☐
Work at computer:	☐	☐	☐	☐	☐	☐	☐
Sit at a desk:	☐	☐	☐	☐	☐	☐	☐
Work on a phone:	☐	☐	☐	☐	☐	☐	☐
Alcoholic drinks:	☐	☐	☐	☐	☐	☐	☐
Mod/Heavy labor:	☐	☐	☐	☐	☐	☐	☐
Stay at home:	☐	☐	☐	☐	☐	☐	☐
Deliver Packages:	☐	☐	☐	☐	☐	☐	☐

Condition List: (Check any condition you have had---- Present or Past)

☐ Alcohol/Drug Addiction	☐ Anemia	☐ Arrhythmia	☐ Arthritis
☐ Asthma	☐ Backaches	☐ Bleeding Disorder	☐ Blood Clots
☐ Blood Transfusions	☐ Blurred Vision	☐ Bowel Problems	☐ Broken Bones
☐ Cancer	☐ Carpal Tunnel	☐ Cataracts	☐ Chicken Pox
☐ Colitis	☐ Collagen Vascular Disease	☐ Constipation	☐ Depression/Anxiety
☐ Diabetes	☐ Digestive Disorder	☐ Dizziness	☐ Eating Disorder
☐ Emphysema	☐ Epilepsy	☐ Fatigue	☐ Female Health Challenges
☐ Gallbladder Disease	☐ Genital Herpes	☐ Glaucoma	☐ Gluten Intolerance
☐ Gout	☐ Headaches	☐ Hearing Loss	☐ Heart attach/Attacks
☐ Heart Murmur	☐ Hemorrhoids	☐ Hepatitis	☐ High Blood Pressure
☐ High Cholesterol	☐ HIV/AIDS	☐ Joint/Back Pain	☐ Kidney Infections
☐ Kidney Stones	☐ Liver Disease/Problems	☐ Lung Disease	☐ Menstrual Cramps
☐ Mental Disorders	☐ Migraines	☐ Neck Pain	☐ Nervousness
☐ Night Sweats	☐ Osteoporosis	☐ Paralysis	☐ Pneumonia
☐ Polio	☐ Prostate Problems	☐ Reflux/Ulcers	☐ Rheumatic Fever
☐ Seizures/Epilepsy	☐ Sexual Dysfunction	☐ Sickle Cell	☐ Sinus Trouble
☐ Stress/Tension	☐ Stroke	☐ Suicidal Tendencies	☐ Thyroid Disease
☐ Tuberculosis	☐ Tumors	☐ Urine Discoloration	☐ Vertigo