New Patient Case History
Seward Chiropractic Center, P.C.

For office use only
*Case History #*_____ *Computer #*_____

Date:_____ Marital Status: Single Married Divorced Separated Widowed

Name:_____ Spouse's Name:_____

Address:_____ Are you a: Full-time student Part-time student

City:_____ Your Occupation:_____

State:_____ Zip Code:_____ Your Employer:_____

Home Phone:(_____)_____ Address:_____

Cellular Phone:(_____)_____ City:_____

Date of Birth:_____Age:_____ State:_____Zip Code:_____

Blood Type:_____SS#:_____ Work Phone:(_____)_____

Sex: Male Female No. of Children:_____ Referred By:_____

Please provide name, address and phone number of person responsible for account if other than yourself:

_____

Have you ever had previous chiropractic care? Yes No If yes, when?_____

Drs. name & address:_____

What is your major complaint?_____

Please explain what happened:_____

Is this interfering with your: (circle those that apply) Work Sleep Daily Routine

Is it getting worse? (circle those that apply) Yes No Constant Comes and Goes

What makes this problem worse? Standing Sitting Lying Bending Lifting Twisting Other_____

Have you been treated by another doctor for your current condition? Yes No If yes, when?_____

Drs. name & address:_____

Other complaints:_____

Circle medications you now take: Nerve pills/Pain killers/Stimulants/Insulin/Tranquilizers/Muscle relaxers/Blood thinners
Other medications:_____

_____

List previous surgeries, treatments, and/or serious conditions and years:_____

_____

_____

Please indicate any of the following symptoms which you now have or have had previously.

O – Occasional
F – Frequent
C – Constant

Circle appropriate frequency

O F C Neck pain or stiffness
O F C Pain between shoulders
O F C Lower back pain
O F C Arthritis
O F C Bursitis/Tendinitis
O F C Swollen joints
O F C Sciatica
O F C Jaw/TMJ problems
O F C Foot/Heel/Toe/problems

Pain or numbness in
O F C Shoulders
O F C Arms
O F C Elbows
O F C Hands
O F C Hips
O F C Legs
O F C Knees
O F C Feet
O F C Ribs

O F C Belching or gas
O F C Constipation
O F C Diarrhea
O F C Difficult digestion
O F C Nausea
O F C Hemorrhoids
O F C Pain over stomach
O F C Ulcers/Colitis
O F C Hiatal hernia
O F C Acid reflux

O F C Colds
O F C Earaches
O F C Tonsillitis
O F C Cold sores
O F C Sinus problems
O F C Chronic cough
O F C Bruise easily

O F C High cholesterol
O F C High triglycerides
O F C High/low blood pressure
O F C Chest pain
O F C Swelling of ankles
O F C Fainting
O F C Seizures/Epilepsy

O F C Allergy
O F C Asthma
O F C Difficulty breathing
O F C Dizziness
O F C Headache
O F C Nervousness/Depression
O F C Fatigue
O F C Difficulty sleeping
O F C Thyroid over/under active
O F C Shingles
O F C Kidney infection/stones

Is there anything we missed?
O F C _____
O F C _____
O F C _____
O F C _____
O F C _____

For women only:

Are you pregnant? Yes No
If yes, how far_____

Are you nursing? Yes No

Have you ever had any of the following conditions? Circle Y (yes) or N (no)

Y N	*Artificial bones/joints*	Y N	Heart attack/Stroke	Y N	Heart murmur	Y N	Glaucoma
Y N	Diabetes	Y N	Congenital heart disease	Y N	Artificial heart valve	Y N	Anemia
Y N	Tuberculosis	Y N	Heart surgery	Y N	Hepatitis	Y N	*Alcohol abuse*
Y N	Cancer	Y N	Pacemaker/Defibrillator	Y N	Emphysema	Y N	Drug abuse
Y N	Chemotherapy	Y N	Mitral valve prolapse	Y N	Rheumatic fever	Y N	Venereal disease

Have you ever:			**Briefly Describe**
Been knocked unconscious?	Yes	No	_____
Used a cane, crutch or other support?	Yes	No	_____
Been treated for a spine or nerve disorder?	Yes	No	_____
Had a fractured bone?	Yes	No	_____
Been hospitalized for other than surgery?	Yes	No	_____

Do you:			
Now take vitamins?	Yes	No	_____
Think you may need vitamins/minerals?	Yes	No	_____
Have an allergy to any drug?	Yes	No	_____
Wear Orthotics?	Yes	No	_____

How long has it been since your last:

	Less than 6 month	6-18 months	Over 18 months	Never
Spinal exam	_____	_____	_____	_____
Physical exam	_____	_____	_____	_____
Blood test	_____	_____	_____	_____
Chest x-ray	_____	_____	_____	_____
Spinal x-ray	_____	_____	_____	_____
Dental x-ray	_____	_____	_____	_____
Urine test	_____	_____	_____	_____

What is your:	Heavy	Moderate	Light	None
Alcohol intake	_____	_____	_____	_____
Coffee/tea intake	_____	_____	_____	_____
Soda pop intake	_____	_____	_____	_____
Tobacco use	_____	_____	_____	_____

Is there anything else we should know regarding your health history?

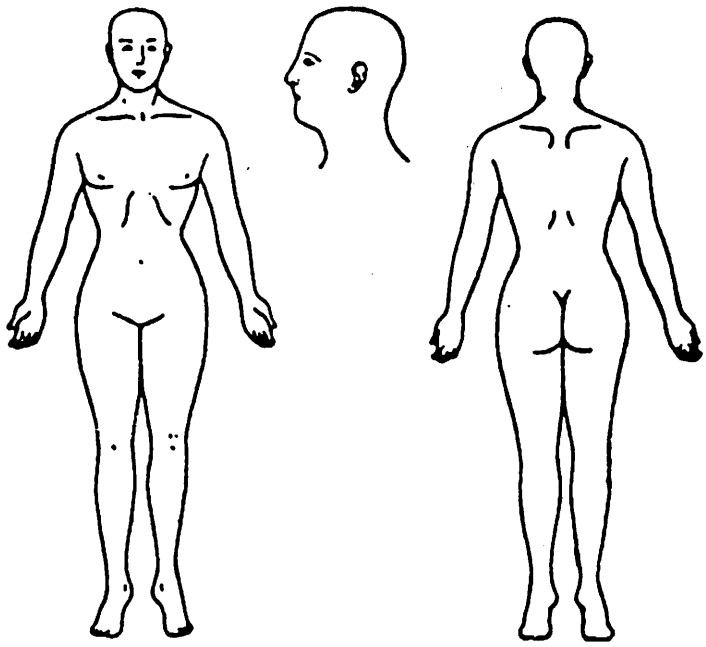
_____

_____

_____

_____

Please **SHADE IN** all areas of concern whether pain, numbness, tingling, burning, aching, stabbing, restricted motions, or other odd sensations.



- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient's Signature _____ Date_____

Guardian or Spouse's
Signature Authorizing Care _____ Date_____

----------**DO NOT WRITE BELOW THIS LINE**----------

Doctor's comments: _____

_____

_____

_____

Patient accepted? Yes_____ No_____

Doctor's Signature _____ Date_____