

## Confidential Case History

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Nickname \_\_\_\_\_

Street Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Birth date \_\_\_\_\_ Present Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

May we contact you:  Home  Cell  Work  E-mail?

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Whom may we thank for telling you about this office? \_\_\_\_\_

Marital Status  Married  Single  Divorced  Separated  Widowed

Minor - If minor, the following signature authorizes the minor to receive chiropractic care in this office. Parent's signature \_\_\_\_\_

Will you be using health insurance?  Yes  No

Have you been involved in a car accident?

Yes  No

Are you here for this reason?

Yes  No

Have you been involved in a work injury?

Yes  No

Are you here for this reason?

Yes  No

Are you the insured?  Yes  No If not, name of insured \_\_\_\_\_

Address of insured \_\_\_\_\_

Relationship to insured \_\_\_\_\_

Do you have secondary policy?  Yes  No

**Please present insurance cards to the front desk so we can make a copy.**

The following information is available in compliance with the HIPAA regulations. It is the policy of this office to maintain the privacy of patient information, and to notify you, by this writing, of our intention to do so. **You should be aware that the open floor plan of this office means that personal information may be overheard. If you should need private time with the doctor, please advise our office team so we may provide that for you.**

The information that I have provided on this form has been completed to the best of my knowledge and with honesty. I authorize the release of any information including diagnosis and records of treatment and x-rays for myself or my minor child. I authorize Dr. Sandra E. Levenson to analyze my spine for the presence of vertebral subluxations and to administer specific chiropractic adjustments.

*The above is accurate to the best of my knowledge:*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Health Related Information

Have you ever received chiropractic care? Yes No    Approx Date \_\_\_\_\_

What is your reason for today's visit? \_\_\_\_\_

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Many people seek chiropractic care because they find that they experience a higher quality of life when receiving regular chiropractic adjustments. You do not need to have a symptom to seek our services. If you do not have any symptoms to report, please skip to Health Goals.

When did you first notice these symptoms? \_\_\_\_\_

Have you had these same symptoms before? Yes No

Have you experienced within the past year...?

\_\_\_neck pain

\_\_\_shoulder pain

\_\_\_leg pain

\_\_\_headaches

\_\_\_hand pain

\_\_\_foot pain

\_\_\_migraines

\_\_\_low back pain

\_\_\_depression \_\_\_fatigue

\_\_\_arm pain

\_\_\_hip pain

\_\_\_ear pain

Anything else not listed \_\_\_\_\_

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Which activities are difficult to perform?

Sitting Standing Walking Bending Lying down Standing to Sitting

What type of pain are you experiencing?

Sharp Dull Throbbing Numbness Achy Shooting Burning

Tingling Stiffness Other \_\_\_\_\_

Rate severity of pain *1 least, 10 most* (Please circle) 1 2 3 4 5 6 7 8 9 10

Is pain constant? \_\_\_\_\_ Does it come and go? \_\_\_\_\_

Have you received any other treatment for this? Yes No

Please describe \_\_\_\_\_

Have you had an x-ray? Yes No    Have you had an MRI? Yes No

Are you taking any medication? Yes No    If yes, please list \_\_\_\_\_

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Have you taken a pain reliever today? Yes No    If yes, what time \_\_\_\_\_

List any surgeries \_\_\_\_\_

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What are your health goals? \_\_\_\_\_

*I hope to be able to help you attain those goals.  
Thank you for visiting our office.*

Doctor's Signature \_\_\_\_\_ Today's date \_\_\_\_\_