ALL~HEALTH CHIROPRACTIC, Inc. (330) 468~2555

CASE #_______________
DATE_________________

NAME____SOCIAL SECURITY #___________________________

ADDRESS__________________________CITY_________________________STATE______________ZIP CODE______________

CELL PHONE #______________________________________HOME/WORK PHONE#___________________________________

DATE OF BIRTH_____________________________AGE________ M_____F_____ AGE OF CHILDREN____________________

EMPLOYER NAME & ADDRESS____OCCUPATION________________

HEALTH INSURANCE COMPANY___________________________________POLICY #___________________________________

IF YOU ARE COVERED BY A SPOUSE OR PARENT'S INSURANCE PLAN PLEASE PROVIDE THE BELOW INFORMATION:

SPOUSE NAME____________________________ EMPLOYER & ADDRESS____

SPOUSE DATE OF BIRTH_____________________________SPOUSE SOCIAL SECURITY #_______________________________

SPOUSE OCCUPATION_________________SPOUSE CELL #____________________WORK PHONE#_____________________

PERSON TO CALL IN CASE OF AN EMERGENCY_____________________________PHONE #____________________________

RELATION________________________________2ND PHONE #_________________________

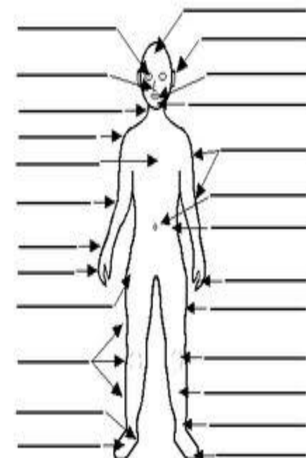
HOW DID YOU FIND OUT ABOUT OUR OFFICE? Newspaper ______ Website________ Friend/Family__________________

PAST AND PRESENT GENERAL HISTORY:
Cardio-Vascular Signs______ Ears, Eyes, Nose & Throat_____________ Family Diseases_____________________________
Gastro-Intestinal Problems________________ Genito-Urinary Symptoms_______ Habits_____________________________
Muscle& Joint Symptoms__________ Respiratory Problems_________________ Skin Problems______________________

LIST ANY OPERATIONS____

PLEASE **CIRCLE** ANY AREAS OF PAIN OR NUMBNESS ACCORDING TO THE BODY BELOW:

HEAD	Pain	Numbness	Right	Left
NECK	Pain	Numbness	Right	Left
SHOULDER	Pain	Numbness	Right	Left
ELBOW	Pain	Numbness	Right	Left
WRIST	Pain	Numbness	Right	Left
HAND	Pain	Numbness	Right	Left
FINGERS	Pain	Numbness	Right	Left
MID BACK	Pain	Numbness	Right	Left
LOW BACK	Pain	Numbness	Right	Left
HIP	Pain	Numbness	Right	Left
THIGH	Pain	Numbness	Right	Left
KNEE	Pain	Numbness	Right	Left
CALF	Pain	Numbness	Right	Left
ANKLE	Pain	Numbness	Right	Left
FOOT	Pain	Numbness	Right	Left
TOES	Pain	Numbness	Right	Left



CURRENT PROBLEM

WHAT IS THE MAIN HEALTH CONDITION YOU WANT TO TALK TO THE DOCTOR ABOUT? ____________________________
____

HOW LONG HAVE YOU HAD THIS CONDITION/SYMPTOM?____
WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?____
IS THE CONDITION GETTING WORSE?_______YES ________NO EPISODES PER DAY _______ WEEK_______ MO_______
CONDITION INTERFERES WITH: WORK _______ SLEEP_______ DAILY ROUTINE _______ OTHER____________________
____

DRUGS TAKING CURRENTLY:
Nerve Pills _____ Pain Killers _____ Muscle Relaxers ______ Tranquilizers ______ None________ Other ____________
OTHER____
MEDICATION
____
____
____

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY:
Been Knocked Unconscious?	☐	☐	____________________
Treated for a Spine or Nerve Disorder?	☐	☐	____________________
Used a Cane, Crutch or Other Support?	☐	☐	____________________
Had any Fractures or Dislocations?	☐	☐	____________________
Had any Accidents or Falls?	☐	☐	____________________
Been Hospitalized other than Surgery?	☐	☐	____________________

Does Any Member of Your Family Have the Following? (please circle)

Arthritis Abnormal Spinal Development Cancer Diabetes Epilepsy Emotional Problems Intestinal Disorders
Lung Disease Neck or Back Pains Scoliosis Spinal Arthritis Other Health Problems? _________________________

If Yes: Father Mother Brother Sister Grandparent Uncle/Aunt

PREVIOUS MEDICAL CARE FOR PRIMARY COMPLAINT

Name and Location of Doctor____ Date Seen_______________
Hospital________________________________ Examinations/ X-Rays/MRIs__________________________________
Condition or Diagnosis_____________________________________ Type of Treatment_______________________
Duration of Treatment__________________________ Results of Treatment: Good _______ Fair ______ Poor_____

PREVIOUS CHIROPRACTIC CARE

Name and Location of Doctor_______________________________________ Date of Last Spine Exam ______________
Condition, Symptom or Diagnosis____________________________________ X-Rays Taken___________________
How often Treated_________ Type of Treatment _______________________ How long was each visit______________
Length of Time Treated for Condition: Days__________ Weeks ____________ Months __________ Year__________
Results of Treatment: Good_____________ Fair _____________ Poor _____________

PLEASE SELECT THE TYPE OF PATIENT CARE DESIRED FOR YOUR CURRENT SYMPTOMS AND CONDITION:
☐ RELIEF CARE ☐ CORRECTIVE CARE ☐ COMPREHENSIVE CARE ☐ Prefer Doctors Opinion

I CERTIFY THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT. I hereby authorize the release of any information required by this office. I also authorize my benefit payments to be made directly to this clinic. I understand that I am financially responsible for all services rendered. All X-Rays are the property of ALL HEALTH CHIROPRACTIC, INC.

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SIGNATURE OF PATIENT OR GUARDIAN