Family Chiropractic of Lederach, LLC

658 Harleysville Pike, Suite 110, Harleysville, PA 19438

Confidential Case History

Patient Name ____Today's Date ______________________
Nickname _____________________________ Present Age _____________ DOB ______________________
Street Address ____
City/State/Zip ____
Home Phone _____________________Work Phone__________________________
Cell Phone ______________________Cell Carrier__________________________(for text appointment reminders)
Best way to contact you? ☐ Home Phone ☐ Cell Phone ☐Work Phone
E-Mail Address ____(for communication from office)
Occupation____________________________________ Employer ____________________________________
How did you hear about this office? ____
Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
☐Patient is a minor (Under 18) Guardian printed name ____
Guardian signature authorizing minor to receive care ____

Will you be using health insurance? ☐Yes ☐No ☐Not sure
Have you had a car accident? ☐Yes ☐No Are you here for this reason? ☐Yes ☐No
Have you had an injury at work? ☐Yes ☐No This office does not bill insurance for Work Comp cases
Are you the insured? ☐Yes ☐No If no, name of insured ____
Address of insured ____Insured's DOB____________
Relationship to insured _________________________________ Do you have secondary policy? ☐Yes ☐No

Have you ever been to a chiropractor? ☐Yes ☐No When? ______________________________________
What are your health goals? ____
What is your reason for today's visit? ____
____
When did you first notice these symptoms? ____
Have you received any other treatment before today for these symptoms? ☐Yes ☐No
Describe what treatment was done, where and when ____
____
Have you had X-Rays? ☐Yes ☐No Have you had an MRI? ☐Yes ☐No
Hospital/Facility where films/studies were taken ____
Are you taking any medications? ☐Yes ☐No If yes, please list____
Have you taken a pain reliever today? ☐Yes ☐No If yes, what time ___________________________________
Have you ever had the same symptoms before? ☐Yes ☐No When? _________________________________
List surgeries ____

Exercise: ☐None ☐Light ☐Moderate ☐Heavy **Smoker:** ☐No ☐Yes ____________________
Water intake: ☐None ☐Light ☐Moderate ☐Heavy **Alcohol:** ☐None ☐Light ☐Moderate ☐Heavy
Stress level: ☐None ☐Light ☐Moderate ☐Heavy **Adequate sleep?** ☐Yes ☐No

For Females: Are you on birth control? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No Due date __________________ Number of children ___________________

The information provided on this form has been completed to the best of my knowledge and with honesty.

Patient Signature____ Date_________________

Doctor's Signature____ Date_________________

Name ______________________________ Today's Date ________________ Date of Birth ________

Main Area of Pain:

____
____
____

Side: ☐ Right ☐ Left ☐ Both

Start date ________________

Pain described as *(circle all)*:

Aching Sharp
Burning Shooting
Dull Stabbing
Numbness Stiff
Throbbing Tingling
Pins & Needles Weakness

Aggravated by *(circle all)*:

Driving Sit to Stand
Lying down Standing
Sitting Walking
Other: ________________

Relieved by *(circle all)*:

Chiropractic Rest
Massage Medication
Heat/Ice Stretching
Exercise Other:
____

Circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10
0 = No pain, 10 = Worst pain

How often:

☐ Occasional (25%)
☐ Intermittent (50%)
☐ Frequent (75%)
☐ Constant (100%)

Worse time of day?
☐ No change
☐ Morning
☐ Afternoon
☐ Evening
☐ During the Night

Daily activities affected?
☐ Yes ☐ No
Describe:________________
____

Sleep affected?
☐ Yes ☐ No

Second Area of Pain:

____
____
____

Side: ☐ Right ☐ Left ☐ Both

Start date ________________

Pain described as *(circle all)*:

Aching Sharp
Burning Shooting
Dull Stabbing
Numbness Stiff
Throbbing Tingling
Pins & Needles Weakness

Aggravated by *(circle all)*:

Driving Sit to Stand
Lying down Standing
Sitting Walking
Other: ________________

Relieved by *(circle all)*:

Chiropractic Rest
Massage Medication
Heat/Ice Stretching
Exercise Other:
____

Circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10
0 = No pain, 10 = Worst pain

How often:

☐ Occasional (25%)
☐ Intermittent (50%)
☐ Frequent (75%)
☐ Constant (100%)

Worse time of day?
☐ No change
☐ Morning
☐ Afternoon
☐ Evening
☐ During the Night

Daily activities affected?
☐ Yes ☐ No
Describe:________________
____

Sleep affected?
☐ Yes ☐ No

Third Area of Pain:

____
____
____

Side: ☐ Right ☐ Left ☐ Both

Start date ________________

Pain described as *(circle all)*:

Aching Sharp
Burning Shooting
Dull Stabbing
Numbness Stiff
Throbbing Tingling
Pins & Needles Weakness

Aggravated by *(circle all)*:

Driving Sit to Stand
Lying down Standing
Sitting Walking
Other: ________________

Relieved by *(circle all)*:

Chiropractic Rest
Massage Medication
Heat/Ice Stretching
Exercise Other:
____

Circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10
0 = No pain, 10 = Worst pain

How often:

☐ Occasional (25%)
☐ Intermittent (50%)
☐ Frequent (75%)
☐ Constant (100%)

Worse time of day?
☐ No change
☐ Morning
☐ Afternoon
☐ Evening
☐ During the Night

Daily activities affected?
☐ Yes ☐ No
Describe:________________
____

Sleep affected?
☐ Yes ☐ No