Family Chiropractic of Lederach, LLC

658 Harleysville Pike, Suite 110, Harleysville, PA 19438
215-256-8006

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

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 _____

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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 _____

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_____

Please present this form to the front desk with your insurance card and driver's license.

Main Area of Pain:

Side: ☐Right ☐Left ☐ Both

Start date _____

Pain described as *(check all)*:

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

Aggravated by *(check all)*:

Driving ☐ Sit to Stand ☐
Lying down ☐ Standing ☐
Sitting ☐ Walking ☐
Other: _____

Relieved by *(check all)*:

Chiropractic ☐ Rest ☐
Massage ☐ Medication ☐
Heat/Ice ☐ Stretching ☐
Other:

Check 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 *(check all)*:

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

Aggravated by *(check all)*:

Driving ☐ Sit to Stand ☐
Lying down ☐ Standing ☐
Sitting ☐ Walking ☐
Other: _____

Relieved by *(check all)*:

Chiropractic ☐ Rest ☐
Massage ☐ Medication ☐
Heat/Ice ☐ Stretching ☐
Other:

Check 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 *(check all)*:

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

Aggravated by *(check all)*:

Driving ☐ Sit to Stand ☐
Lying down ☐ Standing ☐
Sitting ☐ Walking ☐
Other: _____

Relieved by *(check all)*:

Chiropractic ☐ Rest ☐
Massage ☐ Medication ☐
Heat/Ice ☐ Stretching ☐
Other:

Check your level of pain:

0 1 2 3 4 5 6 7 8 9 10
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 = No pain, 10 = Worst pain

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Worse time of day?

☐No change
☐Morning
☐Afternoon
☐Evening
☐During the Night

Daily activities affected?

☐Yes ☐No

Describe:

Sleep affected?

☐Yes ☐No