Brignoni Family Chiropractic

Office #_____
Date _____

CONFIDENTIAL CASE HISTORY

Dear Prospective New Practice Member,
Please complete this information to the best of your ability. Your answers will help us to determine if you are a candidate for chiropractic care. If we do not sincerely believe your condition will respond well, we will not accept your case. Thank you for you assistance.

GENERAL INFORMATION {PLEASE PRINT CLEARLY}

Name_____Street Address_____
City_____State___ Zip_____ Social Security #_____Home Phone#_____

Email Address_____Cell Phone#_____Work Phone #_____

Place of Employment_____Position_____Fax # _____

Date of Birth_____Age _____ Male __Female__Marital Status M S D W ___ # of Children

Spouse's Name {or parent} _____Work Phone #_____

Whom may **we thank** for referring you to our office?_____

HEALTH INFORMATION

What is your major complaint?_____
How long have you had this problem?_____

Has this ever happened before? Yes/No When?_____
Was this as bad as before? Not as bad__ About the same__ Worse this time__

What activities does this condition interfere with?_____

When did you last see a chiropractor?_____Dr. _____Location_____

Was this chiropractic care for your current complaint or another?_____

What spinal maintenance program were you given to follow to maximize the future stability of your spine?

Spinal Exercise? _____ Spinal Stretches? _____ Spinal Traction? _____ Did you follow this program? Yes/No If no, why not? _____

Other doctors consulted for this condition? _____Results?_____

Please list any surgeries and dates_____

Please list any medications you are now taking_____

Are you wearing: _____Heel lifts _____Arch supports **Are you pregnant?** _____

Is this injury related to an automobile accident, a work related injury, or an injury involving someone else's insurance?_____

Past Health History

Do you now or frequently suffer any of the following?

__Headaches __Heart Conditions __Carpal Tunnel __Poor Circulation __Sciatica
__Insomnia __Neck Stiffness __Wrist Pain __Kidney Trouble __Knee Pains
__Dizziness __Ear Infections __Arm Numbness __Skin Conditions __Low Back pain
__Nervousness __Asthma __ Arm/Shoulder Pain __Chronic Fatigue __Leg/Hip pain __Sinus Trouble __Chronic Colds __Indigestion __Stomach Trouble __Leg Numbness __allergies
__Thyroid Problems __Liver Problems __Bladder Problems __Bed Wetting

Women: __PMS __Irregular cycle __Painful Periods __Excessive Flow __Hot Flashes
Children: __Ear Infections __Frequent Colds __Growing Pains __Bed Wetting __Inverted Foot

Occupational Activities

Please describe your job_____
Which of the following activities does your job require you to do often? __Lifting __Pulling __Twisting __Bending __Computer use __Pushing __Typing __Answering Telephones
Exercise __None __Moderate __Daily Type: __Walk __Run __Ski __Aerobics __Other
Hobbies Sports_____Home Activities_____Outdoor Activities_____
Diet __Very Healthy __Watch what I eat __I don't worry about my diet __Unhealthy

What is your health philosophy (What do you believe you should do to be healthy)?_____
_____

Reason for consulting this office:
___Specific Symptom/Problem (Help Symptom but not fix the problem)
___Maximizing Personal Health Potential (Correct the cause of the problem for maximum future stability)

What are your expectations of us?_____
On a scale of 0-10 with 10 being most:
____How committed are you to improving your Optimum Health Potential?
____How committed are you to improving your families Optimum Health Potential?
____How committed are you to preventing arthritis and maximizing the stability of your spine?

Authorization To Administer Care

I authorize Dr. Brignoni and whomever she may designate as her assistant to administer care as necessary.
I also certify that no guarantee or assurance has been made as to the results that may be obtained. INTL_____

X-RAY NOTE: When deemed necessary x-rays will be recommended for exam purposes only, the x-ray negati will remain property of this office, as required by federal law. X-rays will remain on file where they may be seer any time. INTL____

Payment Information

It is the policy of this office that all visits be paid in full at the time services are rendered unless other arrangemer have been made.

Consent to care for a minor child: I hereby authorize the Doctor to administer chiropractic care as deemed necessary to my child. Signed_____
Parent/Legal Guardian_____

I have read the information stated above and have answered everything truthfully and to the best of my knowled

Signature:_____Date:_____