Zelm
CHIROPRACTIC CENTER, S.C.

"We've got your . !"

Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

Confidential Health Information

1. Patient Contact

Clinic ID | Date

Last Name	First Name	M.I.

Age	Date of Birth	Social Security	Sex ❒ male ❒ female

Street	City	State	Zip

Home Phone	Mobile Phone
Work Phone	Email

Who referred you to our office?

2. Patient Personal

Occupation	Employer	Employer Address

Status ❒ single ❒ married ❒ partnered ❒ widowed ❒ separated ❒ divorced

Do you have any allergies to medications? ❒ yes ❒ no List allergy reaction start and end date:

List any prescription or over-the-counter medicines you are currently taking, and the doses (attach copy if necessary).

	Medication	Reason	Dose
1.			
2.			

3. Emergency Contact

Name	Home Phone
Relationship	Work Phone

4. Spouse or Guardian

Last Name	First Name	M.I.

Best Contact Number	Date of Birth

5. Health Complaints

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does this **primary** complaint feel? ❒ dull/achy ❒ sharp ❒ numb ❒ tingling ❒ burning ❒ cold

How often do you experience the **primary** complaint? ❒ constantly ❒ daily ❒ weekly ❒ monthly ❒ yearly

Using the scale below, rate how your **primary** complaint affects your life (mark only one box below).

No pain or discomfort — Severe

1 2 3 4 5 6 7 8 9 10

Does this pain radiate? ❒ no ❒ yes, to what location?

What makes your problem worse?	What makes your problem better?

If you have missed work because of your **primary** complaint, when was your last day of work?

List any tests, studies, or medications received for this condition:

Do you have any other condition other than what brings you here? ❒ yes ❒ no If **YES**, list here:

If due to an accident, injury, or illness, please describe:

Doctor's remarks:

6. Lifestyle & Habits

What are your exercise activities (mark all that apply)? ❒ I don't exercise ❒ walking ❒ swimming ❒ weight lifting ❒ yoga/pilates ❒ stretching/flexibility ❒ running/treadmill/rowing/climbing ❒ group exercise classes ❒ Other________

List any nutritional supplements you are currently taking:

7. Family History

List any conditions as they pertain to your family history:

Mother ________ Brother________

Father ________ Sister ________

8. Conditions Mark any conditions that pertain to you.

appendicitis	❒ yes	❒ no	heart disease	❒ yes	❒ no	neck pain	❒ yes	❒ no	stroke	❒ yes	❒ no
arthritis	❒ yes	❒ no	low back pain	❒ yes	❒ no	osteoporosis	❒ yes	❒ no	thyroid disorder	❒ yes	❒ no
cancer	❒ yes	❒ no	mental disorder	❒ yes	❒ no	post-polo	❒ yes	❒ no			
epilepsy	❒ yes	❒ no	multiplesclerosis	❒ yes	❒ no	scoliosis	❒ yes	❒ no			

9. Injuries

List any injuries, car accidents, etc., and dates:

____

____

10. Hospital/Medicine

What types of surgeries have you had?

Do you have any other implantable medical devices in your body? ❒ yes ❒ no

List any broken bones or dislocations that you have had.

Have you ever been to a chiropractor before? ❒ yes ❒ no Approximate date of last adjustment: Date of last physical examination:

11. Pregnancy (women only)

X-rays are contra-indicated during pregnancy. This clinic does not knowingly X-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now. Are you pregnant? ❒ yes ❒ no

On what day did your last period begin?

12. Insured Information Are the insured and patient the same person? ❒ Yes ❒ No **If YES, do not complete section 12.**

Last Name	First Name		M.I.
Street	City	State	Zip

Age	Date of Birth	Social Security #	Sex ❒ male ❒ female

Relationship to insured ❒ spouse ❒ dependent ❒ other________

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendations will be based on what we believe is best for you—supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care.
- I will be informed of fees and charged before the associated procedure or service is performed.
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered.

____

Patient or Guardian Signature

____

Date