ABBOTT FAMILY CHIROPRACTIC, PC

Hayes, VA

Confidential Case History

Name:____ Date:________________
Age:__________ Occupation:____
Sports/Activities/Hobbies:____
____

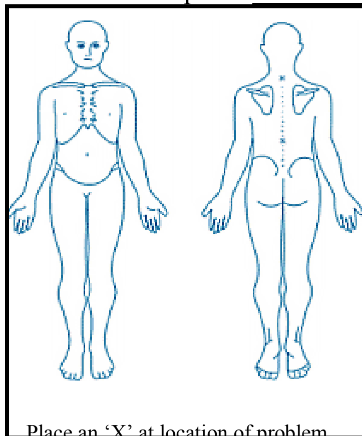
Marriage Status: ☐ Single ☐ Married ☐ Divorced # of Children:___________________
How did you find out about our office?______________________________________

Have you ever been under chiropractor care before? ☐ Yes ☐ No
If Yes, Name of Chiropractor:____
City:________________________________ State:__________ Last visit date:__________
List most recent traumas (*auto accidents, falls, sport injuries, fractures, etc.*):

1. ____ Date:____________
2. ____ Date:____________
3. ____ Date:____________

Primary Condition

Describe Complaint:____



Place an 'X' at location of problem

When did it start? ____________

Have you had it in the past? ☐ Yes ☐ No When? ______________

Does the pain ☐ come & go or is it ☐ constant?

On a scale from 1-10 with 10 being the worst, circle the level of pain
1 2 3 4 5 6 7 8 9 10

Check all boxes that apply ☐ Sharp/Stabbing ☐ Burning ☐ Dull
☐ Tingling ☐ Numbness ☐ Other
____

Does the pain travel to other areas? ☐ Yes ☐ No / Where?__________

Have you seen other doctors for this problem? ☐ Yes ☐ No
If Yes, Who? ________________________________
What makes it better?________________________________
What makes it worse? ________________________________

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing ☐ Sneezing
☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping ☐ Other ______________

Is this the result of an automobile accident? ☐ Yes ☐ No Work related injury? ☐ Yes ☐ No
If yes to either, explain: ____
What other treatment have you had for this condition? ________________________

Medications

Please list all medications and dosage(if known) that you are currently taking:
1)____________________ 2)____________________ 3)____________________
4)____________________ 5)____________________ 6)____________________

Supplements

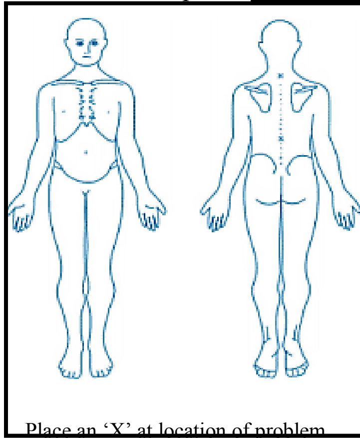
Please list all vitamin and nutritional supplements that you are currently taking:
1)____________________ 2)____________________ 3)____________________
4)____________________ 5)____________________ 6)____________________

Surgeries (with date)

1) ____
2) ____

Additional Condition

Describe Complaint: ______________________________



When did it start? _____________

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☐ Tingling ☐ Numbness ☐ Other

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If Yes, Who? ____

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What makes it worse? ____

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☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping ☐ Other _______________

Is this the result of an automobile accident? ☐ Yes ☐ No Work related injury? ☐ Yes ☐ No

If yes to either, explain: ____

What other treatment have you had for this condition? ______________________________

Family History

Insert age and check any that apply

	Age (if living)	Heart Disease	Diabetes	Cancer	Neck Pain	Low Back Pain	Carpal Tunnel	Headaches	Smoker
Self									
Mother									
Father									
Brother									
Sister									
Other									

Primary Physician

I authorize Abbott Family Chiropractic, PC, to communicate with my primary physician about the care I receive at this office.

Primary physician: ______________________ City: ______________ St: ______

Signature: ____ Date: ____________

Female Only

Are you currently having menstrual cycles? ☐ Yes ☐ No If Yes, first day of your last cycle? ______

Is there any chance that you are pregnant? ☐ Yes ☐ No If No, Sign here: ________________

Financial Arrangement

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our customers are able to receive the care that they need in an affordable manner. If you have insurance coverage, our office will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days, will ultimately become your responsibility. The amount of your insurance coverage and the out of pocket expenses will be discussed in detail and convenient payment plans will be available.

I have read and understand the statements above and give the doctor permission to evaluate me.

Name: _______________ Signature: ____________________________ Date: ________