Ellis
Chiropractic

1302 South Medford Drive • Lufkin, Texas 75901 • 936.639.1488

PATIENT CASE HISTORY

Name _____ Date _____

Address _____ City/Zip _____

Home Ph _____ Work _____ Cell _____

SSN _____ Date of Birth _____ Email _____

Employer _____ Work Status: Full-Time Part-Time Not Employed Retired

Marital Status: S M D W Who Referred You To This Office _____

Student: ( ) Yes ( ) No If YES, Full Time Part Time What School _____

Insurance: _____ Relationship to Insured: Myself Spouse Other _____

If the insurance is in the name of your spouse or parent, please answer the following:

Name of Spouse / Parent _____ Spouse / Parent Date of Birth _____

SSN of Spouse / Parent _____ Spouse / Parent Phone #_____

Chief Complaint / List Current Problems

1. _____ Duration-(How Long) _____ Previous Episodes _____
2. _____ Duration-(How Long) _____ Previous Episodes _____
3. _____ Duration-(How Long) _____ Previous Episodes _____

Are your present problems due to an injury? ( ) No ( ) Yes Date of Injury _____

Please Mark the intensity of your pain today

1 – NO PAIN
10 – MOST INTENSE PAIN EVER FELT

Example _____ Neck _____
1 2 3 4 5 6 7 8 9 10

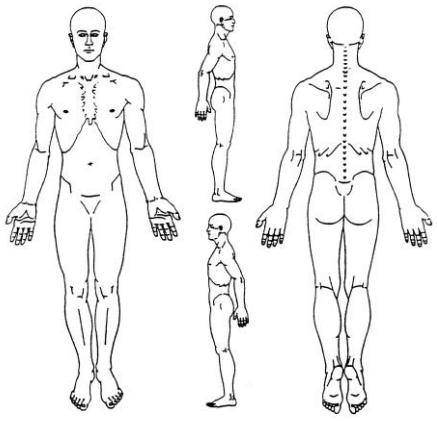
1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below

N – Numbness P – Pain T – Tingling
A – Ache S – Soreness ST - Stiffness



HABITS

- ☐ Smoking Packs/Day _____
- ☐ Drinking Alcohol Per Day _____
- ☐ Coffee Cups Per Day _____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily

Type _____

FAMILY HISTORY

	Diabetes	Heart	Stroke	Cancer	Back
Mother					
Father					
Brother					
Sister					

Please check if you have ever had any of the associated symptoms:

GENERAL SYMPTOMS
- ☐ Allergies
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Loss of Weight
- ☐ Numbness arms/legs

CARDIO-VASCULAR
- ☐ High Blood Pressure
- ☐ Previous Heart Trouble
- ☐ Stroke
- ☐ Swelling Ankles

MUSCLES & JOINTS
- ☐ Arthritis
- ☐ Foot Trouble
- ☐ Hernia
- ☐ Stiff Neck
- ☐ Swollen Joints
- ☐ Tremors/Twitching
- ☐ Weakness

EYE/EAR/NOSE/THROAT
- ☐ _____

RESPIRATORY
- ☐ _____

FOR WOMEN ONLY
- ☐ Miscarriage
- ☐ Pregnant at this time

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Inability to Control Urine
- ☐ Prostate Trouble

SKIN OR ALLERGIES
- ☐ _____

GASTRO-INTESTINAL
- ☐ _____

OPERATIONS AND PROCEDURES

DATE		DETAILS
_____	Back Operation	_____
_____	Hernia	_____
_____	Female Organs	_____
_____	Other	_____

☐ I have never had any operations / surgeries.

List any accidents or falls and dates: ☐ Car _____ ☐ Recreational Vehicle _____

☐ Sports _____ ☐ School _____ ☐ Other _____

Have you ever had a spinal tap(s) or spinal injection(s)? ☐ Yes ☐ No

Have you ever had X-rays taken? ☐ No ☐ Yes When? _____ By whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication(s) – prescription or over-the-counter? ☐ No ☐ Yes What drugs? _____

_____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare the necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition(s) nor for any medical diagnosis.

Patient/s/Guardian's Signature X _____ Date _____

PATIENT HISTORY

Name: _____ Date: _____

Please answer all questions thoroughly

Completion of this form helps the doctor determine what's wrong with you.
He will not see you without this form being filled out completely.

1. Please describe the location of your pain. Where does it start? _____

_____

2. Are your symptoms constant or do they come and go? _____

3. Did your symptoms appear gradually or suddenly? _____

4. When did your symptoms first appear? _____

5. What makes your symptoms worse (bending, sitting, riding, etc.)? _____

_____

6. What makes your symptoms better (heat, cold, medication, rest)? _____

_____

7. Please describe the symptoms (sharp, dull, ache, burning, shooting, throbbing, etc.) _____

_____

8. Is pain worse in the morning, afternoon, evening, night or none. _____

9. Does it radiate (arm, fingers, leg, toes, back)? _____

10. What might you have done to cause your symptoms? _____

_____

11. Have you ever had a similar episode in the past? _____

12. Have you seen another Doctor for this condition? If so, who? _____

13. What was his/her diagnosis? _____

14. What treatment did he/she prescribe? _____

15. Please describe what you do in your job or occupation. _____

16. For Women: Are you pregnant (or possibly could be)? _____

NOTES: _____

_____

_____

_____

_____