Priestley Chiropractic

Dr. Walter F. Priestley, DC DICCP Dr. Christopher Wider, DC

CONFIDENTIAL PATIENT CASE HISTORY

Form Instructions: This form can be filled in electronically using Adobe PDF reader (free) and printed, or if you prefer to hand write, simply print the form to fill it in, and bring the completed form to your first appointment. Use the tab key and/or the mouse, to move between fields to fill-in the form electronically. To sign the form, you can use a digital signature, or print out the form and sign.

Name _____ Who may we thank for referring you? _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Age _____ Marital Status _____ No. of Children _____

Home Phone: _____ Cell Phone: _____ E-Mail _____

Occupation _____ Employer _____ Work Phone _____

Emergency Contact and Phone Number _____

Good communication between doctors and patients is essential. We often need to do follow up calls and e-mails for patients in pain. Please provide us with your e-mail address and best phone numbers to reach you. You will be provided with our personal e-mails and cell phone numbers.

HEALTH INFORMATION:

What is your major complaint? _____

Other complaints _____

Onset of condition _____

Other doctors who treated this condition _____

If this a Worker's Compensation case, list the Date of Injury _____

If this is a No-Fault case, list the Date of Injury _____

If you have health insurance, please provide us with Insurance Company Name: _____

If you would like to pre-certify your benefits, please provide us with the following information from your insurance card:

Member ID: _____ Group #: _____

I authorize Dr. Priestley's office to obtain necessary medical records related to my above referenced condition.

Signature _____ *Date*_____

If the patient is a minor, I authorize Dr. Priestley or Dr. Wider to evaluate and treat my child.

Signature of parent/guardian _____ *Date* _____

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Patient Name _____ *Date* _____

What type or regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height _____ (Feet Inches) Weight_____ lbs

For each of the Conditions listed below, place an "X" in the Past column if you have had the condition in the past. If you presently have a condition listed below, place an "X" in the Present column. Use the Tab key or mouse to scroll through conditions. See Example Indicated Below.

Past	Present	Condition
☒	☒	**Example, Type or Print X In Box**
☐	☐	**Headaches**
☐	☐	**Neck Pain**
☐	☐	**Upper Back Pain**
☐	☐	**Mid Back Pain**
☐	☐	**Low Back Pain**
☐	☐	**Shoulder Pain**
☐	☐	**Elbow/Upper Arm Pain**
☐	☐	**Wrist Pain**
☐	☐	**Hand Pain**
☐	☐	**Hip/Upper Leg Pain**
☐	☐	**Knee/Lower Leg Pain**
☐	☐	**Ankle/Foot Pain**
☐	☐	**Jaw Pain**
☐	☐	**Joint Swelling/Stiffness**
☐	☐	**Arthritis**
☐	☐	**Rheumatoid Arthritis**
☐	☐	**General Fatigue**
☐	☐	**Muscular Incoordination**
☐	☐	**Visual Disturbances**
☐	☐	**Dizziness**
☐	☐	**Diabetes**
☐	☐	**Chest Pains**
☐	☐	**Stroke**
☐	☐	**Angina**
☐	☐	**Asthma**
☐	☐	**Chronic Sinusitis**
☐	☐	**Cancer**
☐	☐	**Tumor**
☐	☐	**Systemic Lupus**
☐	☐	**Epilepsy**

Past	Present	Condition
☐	☐	**Kidney Stones**
☐	☐	**Kidney Disorders**
☐	☐	**Bladder Infection**
☐	☐	**Painful Urination**
☐	☐	**Loss of Bladder Control**
☐	☐	**Prostate Problems**
☐	☐	**Abnormal Weight Gain/Loss**
☐	☐	**Loss of Appetite**
☐	☐	**Abdominal Pain**
☐	☐	**Ulcer**
☐	☐	**Hepatitis**
☐	☐	**Liver/Gall Bladder Disorder**
☐	☐	**Excessive Thirst**
☐	☐	**Frequent Urination**
☐	☐	**Smoking/Use Tobacco Products**
☐	☐	**Drug/Alcohol Dependence**
☐	☐	**Allergies**
☐	☐	**Depression**
☐	☐	**Dermatitis/Eczema/Rash**
☐	☐	**HIV/AIDS**
☐	☐	**Birth Control Pills**
☐	☐	**Hormonal Replacement**
☐	☐	**Pregnancy**
☐	☐	_____

Other Health Problems/Issues

☐	☐ _____
☐	☐ _____
☐	☐ _____
☐	☐ _____

What is your usual blood pressure? _____

Indicate if an immediate family member has had any of the following: □ Rheumatoid Arthritis □ Heart Problems
□ Diabetes □ Cancer □ Lupus □ Other _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

Are any of these medications used to control blood pressure? _____

Any allergies to medications?_____ If so, what type of reaction? _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

PRIMARY CARE PHYSICIAN

In some cases we like to keep your primary care physician informed of your condition and care plan. Unless you have any objections, please be kind enough to include your primary care physician's name and address if known.

Dr**.** _____ Address _____

PRIVACY NOTICE

Essentially our privacy policy states that we do not give out your medical information to anyone other than your insurance company, yourself, or another doctor involved in your care. If you would like to see the complete detailed policy, you may request a copy at the front desk. If you would like us to release your medical information to someone other than those listed above, we need to be notified verbally or in writing.

If you request any specific restrictions regarding your privacy, please discuss it with the doctor.

By signing below, you acknowledge that you have read and understand the above.

Signature _____ Date _____

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