Cengia Chiropractic Center

Case History/Patient Information

Date: _____

Name: _____ Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Occupation: _____ Employer: _____

Marital Status (Circle One): Married Single Widowed Divorced Spouse Name: _____

Do you have any children? ☐ No ☐ Yes If yes, how many and what are their ages? _____

Family Medical Doctor: _____

Who may we thank for referring you to our office? _____

History of Present Complaint

Major complaint/purpose of this appointment: _____

Date symptoms appeared/accident happened: _____

Is this due to: ☐ Auto Accident? ☐ Work Injury? ☐ A fall? ☐ Other: _____

Have you ever had the same or a similar condition? ☐ No ☐ Yes If yes, when and describe: _____

Past Medical History

Have you ever been diagnosed as having or suffering from? (Circle all that apply)

Fractures
Rheumatoid Arthritis
Osteoarthritis
Seizures/Convulsions
Headaches
Neck Pain
Stiff Neck
Sleeping Problems
Back Pain
Nervousness
Tension
Irritability
Chest Pain/Tightness

Dizziness
Low Blood Pressure
High Blood Pressure
Pacemaker
Stroke
Cancer
Hernias
Shoulder/Arm Pain
Numbness in Fingers
Numbness in Toes
Difficulty Urinating
Extremity Weakness
Breathing Problems

Fatigue
Light Sensitive Eyes
Ringing in Ears
Loss of Balance
Eating Disorder
Depression
Ulcers
Fainting
Bowel Changes
Cold Feet
Cold Hands
Muscle Spasms
Frequent Colds

Fever
Sinus Problems
Measles
Mumps
Chicken Pox
Diabetes
Indigestion Problems
Joint Pain/Swelling
Menstrual Difficulties
Weight Loss/Gain
Loss of Memory
Other: _____

Have you had any:

Major Illnesses? ☐ No ☐ Yes If yes, please describe: _____

Hospitalization? ☐ No ☐ Yes If yes, please describe: _____

Surgeries? ☐ No ☐ Yes If yes, please describe: _____

Injuries? ☐ No ☐ Yes If yes, please describe: _____

Have you been treated for any health conditions by a physician in the last year? ☐ No ☐ Yes If yes, please describe: _____

Are you taking any medications or prescription drugs? ☐ No ☐ Yes If yes, please list: _____

_____

Social History

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, number of drinks per week? _____

Do you use any tobacco products? ☐ No ☐ Yes If yes, how often per day? _____

Do you take any vitamin supplements? ☐ No ☐ Yes If yes, please list _____

Do you consume caffeine? ☐ No ☐ Yes If yes, how much per day? _____

Do you exercise? ☐ No ☐ Yes If yes, what is the type and frequency?_____

What percentage of your time during the day (at home and/or at your job) do you spend:

Lifting _____ Sitting_____ Bending_____ Working at a computer_____

What is your typical stress level? _____

What are your hobbies?_____

Family History

Parents

- Mother: Current age if still living: _____ Cause of death and age if deceased: _____
- Father: Current age if still living: _____ Cause of death and age if deceased: _____

Do you have any family members who suffer from the same condition that brought you in today? ☐ No ☐ Yes

If yes, please list _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat and disease or condition other than vertebral subluxation. However, if during the courses of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Not do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

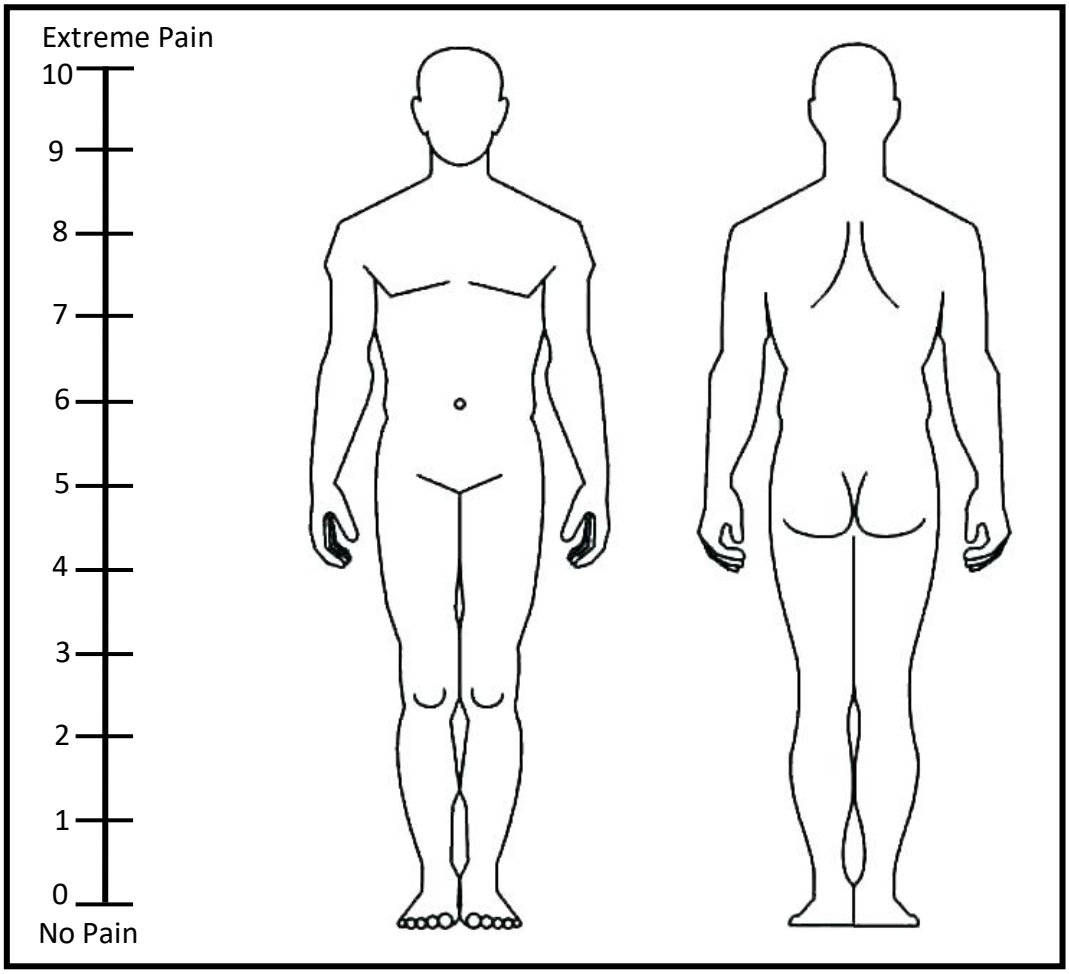
I _____, (please print your name) have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in the office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature: _____

Date: _____

Pain Assessment

Name: _____ Date: _____



Please indicate the area(s) of your pain on the figures above. Then mark the severity of your pain on the scale of 0-10. Describe any changes in your condition of any new concerns:

_____

_____

_____

Patient's Signature: _____