CASE HISTORY

Name: _____ Age: _____ Date: _____ Case Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone:(H) _____ (C) _____ Fax: _____ E-mail: _____
Date of Birth: _____ Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W # of Children: _____
Occupation: _____ Employer: _____ Telephone (Work): _____ Ext. _____
Insured's Name: _____ Phone: _____ Insured's Date of Birth: _____
Spouse's Name: _____ Spouse's Occupation: _____
Spouse's Employer: _____ Spouse's Telephone (Work): _____
Past Chiropractic Care: ❑ Yes ❑ No When? _____ Doctor's Name: _____
Results: _____ Referred by: _____
Insurance Company: _____ Telephone: _____
Social Security Number: _____ Driver's License Number: _____ State: _____
Spouse's Insurance Company: _____ Telephone: _____
Spouse's Social Security Number: _____ Spouse's Driver's License Number: _____
Emergency Contact: _____ Relationship _____ Contact Number _____

Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the Job ❑ Auto Accident ❑ Personal Injury ❑ Other: _____
Has the accident been reported? ❑ No ❑ Yes ❑ To Employer ❑ Auto Carrier ❑ Other: _____
Are you now or have you ever been disabled? (Service or Work)? ❑ No ❑ Yes When? _____ Why? _____
Have you retained an attorney? ❑ No ❑ Yes Name & Address: _____

Pain Symptoms: (in order of severity)
1. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
2. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
3. _____ Began-(Mo/Yr): _____ Previous Episodes: _____

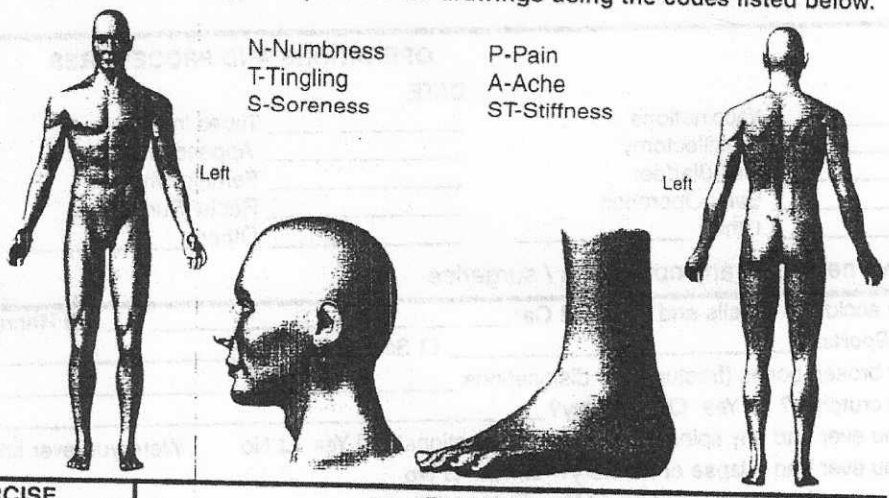
Please mark the intensity of your pain today.
0 - NO PAIN
10 - INTENSE PAIN
Example Neck 0 1 2 3 ④ 5 6 7 8 9 10

1. _____ 0 1 2 3 4 5 6 7 8 9 10
2. _____ 0 1 2 3 4 5 6 7 8 9 10
3. _____ 0 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
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



DOCTORS USE ONLY

_____
_____
_____
_____

HABITS

❑ Smoking Packs/Day: _____
❑ Drinking Alcohol: _____
❑ Caffeine Cups/Day: _____

EXERCISE

❑ None
❑ Light Activity
❑ Moderate Activity
❑ Active
❑ Very Active
❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑ _____
Father	❑	❑	❑	❑	❑ _____
Brother,# of: ____	❑	❑	❑	❑	❑ _____
Sister,# of: ____	❑	❑	❑	❑	❑ _____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 541	Appendicitis	❑ 280	Anemia	❑ 429.9	Heart Disease	❑ 716	Arthritis
❑ 480	Pneumonia	❑ 055	Measles	❑ 240	Goiter	❑ 345	Epilepsy
❑ 390	Rheumatic Fever	❑ 072	Mumps	❑ 487	Influenza	❑ 319	Mental Disorder
❑ 045	Polio	❑ 052	Chicken Pox	❑ 511	Pleurisy	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

(OVER)

Never	Previously	Presently	GENERAL SYMPTOMS	
☐	☐	☐	995.3	Allergy (What)___
☐	☐	☐	490	Bronchitis
☐	☐	☐	780.9	Chills
☐	☐	☐	780.39	Convulsions
☐	☐	☐	780.4	Dizziness
☐	☐	☐	780.2	Fainting
☐	☐	☐	780.79	Fatigue
☐	☐	☐	780.6	Fever
☐	☐	☐	784.0	Headache
☐	☐	☐	780.52	Loss of Sleep
☐	☐	☐	783	Loss of Weight
☐	☐	☐	799.2	Nervousness
☐	☐	☐	729.2	Neuralgia
☐	☐	☐	780.8	Sweats
☐	☐	☐	786.07	Wheezing
☐	☐	☐	311	Depression

Never	Prev	Pres	GASTRO-INTESTINAL	
☐	☐	☐	787.3	Belching/Gas/Bloating
☐	☐	☐	789.0	Abdominal Pain
☐	☐	☐	564.0	Constipation
☐	☐	☐	787.91	Diarrhea
☐	☐	☐	783.6	Excessive Eating
☐	☐	☐	575.9	Gall Bladder Trouble
☐	☐	☐	455	Hemorrhoids (piles)
☐	☐	☐	782.4	Jaundice
☐	☐	☐	794.8	Liver Trouble
☐	☐	☐	787.02	Nausea
☐	☐	☐	536.9	Stomach Pain
☐	☐	☐	783.0	Poor Appetite
☐	☐	☐	536.8	Poor Digestion
☐	☐	☐	787.03	Vomiting
☐	☐	☐	578.0	Vomiting Blood
☐	☐	☐	783.5	Excessive Thirst
☐	☐	☐	536.8	Indigestion
☐	☐	☐	569.3	Rectal Bleeding

Never	Previously	Presently	EYE/EAR/NOISE/THROAT	
☐	☐	☐	493.9	Asthma
☐	☐	☐	378.9	Crossed Eyes
☐	☐	☐	389.9	Deafness
☐	☐	☐	388.70	Earache
☐	☐	☐	388.60	Ear Discharge
☐	☐	☐	388.30	Ear Noises
☐	☐	☐	240.9	Enlarged Thyroid
☐	☐	☐	460	Frequent Colds
☐	☐	☐	477	Hay Fever
☐	☐	☐	784.49	Hoarseness
☐	☐	☐	478.1	Nasal Obstruction
☐	☐	☐	784.7	Nosebleeds
☐	☐	☐	379.91	Pain in Eyes
☐	☐	☐	368.9	Poor Vision
☐	☐	☐	461.9	Sinusitis
☐	☐	☐	462	Sore Throat
☐	☐	☐	463	Tonsillitis
☐	☐	☐	786.2	Persistent Cough
☐	☐	☐	787.2	Difficulty Swallowing
☐	☐	☐	523.8	Bleeding Gums

Never	Previously	Presently	RESPIRATORY	
☐	☐	☐	786.50	Chest Pain
☐	☐	☐	786.2	Chronic Cough
☐	☐	☐	786.09	Difficulty Breathin
☐	☐	☐	786.3	Spitting Blood
☐	☐	☐	786.4	Spitting Phlegm

GENITO-URINARY

☐	☐	☐	788.36	Bed Wetting
☐	☐	☐	599.7	Blood in Urine
☐	☐	☐	788.4	Frequent Urination
☐	☐	☐	788.3	Lack of Bladder Control
☐	☐	☐	590.9	Kidney Infection
☐	☐	☐	788.1	Painful Urination
☐	☐	☐	601.9	Prostate Trouble

MUSCLES/JOINTS/BONES

☐	☐	☐	724.5 Backache
☐	☐	☐	719.7 Foot Trouble
☐	☐	☐	550 Hernia
☐	☐	☐	719.1 Pain Between Shoulders
☐	☐	☐	724.6 Painful Tail Bone
☐	☐	☐	723.9 Stiff Neck
☐	☐	☐	781.9 Spinal Curvature
☐	☐	☐	719.0 Swollen Joints
☐	☐	☐	781.0 Tremors/Twitching
☐	☐	☐	782 Arm Trouble

CARDIO-VASCULAR

☐	☐	☐	401.9 High Blood Pressure
☐	☐	☐	458.9 Low Blood Pressure
☐	☐	☐	786.51 Pain Over Heart
☐	☐	☐	785.9 Poor Circulation
☐	☐	☐	438 Previous Heart Trouble
☐	☐	☐	785.0 Rapid Heart
☐	☐	☐	427.89 Slow Heart
☐	☐	☐	436 Strokes
☐	☐	☐	719.7 Swelling Ankles
☐	☐	☐	454 Varicose Veins

SKIN OR ALLERGIES

☐	☐	☐	680.9 Boils
☐	☐	☐	924.9 Bruising Easily
☐	☐	☐	701.1 Dryness
☐	☐	☐	691.8 Eczema
☐	☐	☐	708.9 Hives or Allergy
☐	☐	☐	698.9 Itching
☐	☐	☐	782.0 Sensitive Skin
☐	☐	☐	782.1 Skin Eruptions

FOR WOMEN ONLY

☐	☐	☐ 625.3 Cramps or Backaches
☐	☐	☐ 626.2 Excessive Flow
☐	☐	☐ 627.2 Hot Flashes
☐	☐	☐ 626.4 Irregular Cycle
☐	☐	☐ 634.9 Miscarriage
☐	☐	☐ 625.3 Painful Periods
☐	☐	☐ 623.5 Vaginal Discharge
☐	☐	☐ 611.79 Lump in Breast
☐ Yes	☐ No	Pregnant at this time?
☐ Yes	☐ No	Have you had a mammogram?
_____		Last Pap Smear Date
_____		By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other: _____	_____	Other: _____	_____	Other: _____

☐ I have never had any operations / surgeries

List any accidents or falls and dates: ☐ Car:_____ ☐ Recreation: _____
☐ Sports:_____ ☐ School:_____ ☐ Other:_____
List any broken bones (fractures) or dislocations: _____
Ever on crutches? ☐ Yes ☐ No Why? _____
Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No Were you ever knocked unconscious? ☐ Yes ☐ No
Have you ever had a lapse of memory? ☐ Yes ☐ No
Have you ever had X-rays taken? ☐ Yes ☐ No 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 - prescription or over-the-counter? ☐ Yes ☐ No What drugs?_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X_____ Date:_____

Doubrava Family Chiropractic

32 Washington Ave.

Endicott, NY 13760

HIPAA Information

Patients Name _____ DOB _____

May we leave appointment information on (please circle)

Home Telephone Yes No

Cell Phone Yes No

May we leave Medical Information on (please Circle)

Answering Machine Yes No Cell Phone
Yes No

Office Voicemail Yes No Send Through Mail
Yes No

Send Through Email Yes No With Another Person Yes
No

I hereby give permission to release information regarding my care protected health information to the following individuals (Parents, Family members, Friends, or others who need to know about health care).

Name of person	Relationship	Contacts Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have received and reviewed the HIPAA statement

_____ _____

Signature of Patient or Guardian **Date**

Dr. Cory Doubrava - Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his\her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may aiso be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations or joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular incident, has been estimated at one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other Treatment Options: May include over-the-counter analgesics, prescription medications, injections, and surgery.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the conditions and make future rehabilitation more difficult.

I understand that my doctor will share with me his opinion regarding protential results from chiropractic treatment for my condition and will discuss treatment options with me before I consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____

_____

Printed name **Signature**
Date

Consent to Treat Minor - For use when Applicable

I hereby authorize Dr. Cory Doubrava to administer chiropractic care, as deemed necessary,

to my child: _____

_____ _____

_____

Printed name
Signature **Date**