Dr. Theresa Alianell 6416 Sonyea Rd., Mount Morris, NY 14510 585-658-4180
CONFIDENTIAL PATIENT CASE HISTORY Date: _____

Dear patient: please complete this questionnaire as accurately as possible- please feel free to us the back side of this paper. Your answers will help us determine if chiropractic care can help you. Thank you!

NAME: _____
ADDRESS: _____ CITY _____ STATE _____ZIP _____
HOME TELEPHONE: _____ AGE: _____ BIRTHDATE: _____ MARITIAL STATUS: M S W D
CELL TELEPHONE: _____ EMPLOYER _____ NAME OF SPOUSE: _____
OCCUPATION: _____ REFERRED BY: _____NUMBER OF CHILDREN: ____
EMAIL: _____

INSURANCE INFORMATION: If you are covered by an insurance please show your ID card to the receptionist
Are you covered by Medicare? Yes _____ No _____
Is your condition due to an auto accident? Yes _____ No _____
Is your condition due to a work related injury? Yes _____ No _____

MAIN COMPLAINT:
What is your major complaint? _____
_____
When did it start? _____
Was it an injury at home or elsewhere? _____
Have you had this or similar conditions in the past? Y N Explain: _____
Does it radiate to any other part of your body? Y N Where? _____
Describe your pain (dull, sharp, burning, numbness, soreness, stiffness etc: _____
_____
Has your condition been getting: better worse staying the same
What makes your symptoms better? _____
What makes your symptoms worse? _____
Have you tried home remedies? Y N What? _____
What doctors have you seen for this problem? Y N Who?_____
Have you had any tests for this condition? Y N What? _____
Has your condition affected your daily activities? Y N How: _____
Have you been unable to work as a result of your current problem? Y N
Have you had previous chiropractic care? _____ Did it help? _____

PAST HISTORY:
Who is your primary physician? _____
Have you been diagnosed with any other conditions or diseases? Y N What: _____
_____
Have you had any broken bones? Y N Where: _____
List medications taking: _____
_____
_____
List surgical operations and years performed: _____
_____
Do you: (please circle) Smoke Drink Use recreational drugs
Do you have any allergies? _____
Have you been in an auto accident: Past year _____ Past 5 years _____ Over 5 years _____ Never ____
Any other personal injuries or accidents? _____

FOR FEMALES: Are you pregnant: _____ If yes, how long: _____

FOR MINORS: Name and address of parent/legal guardian:_____
_____

Have you been diagnosed or been told you have the following?

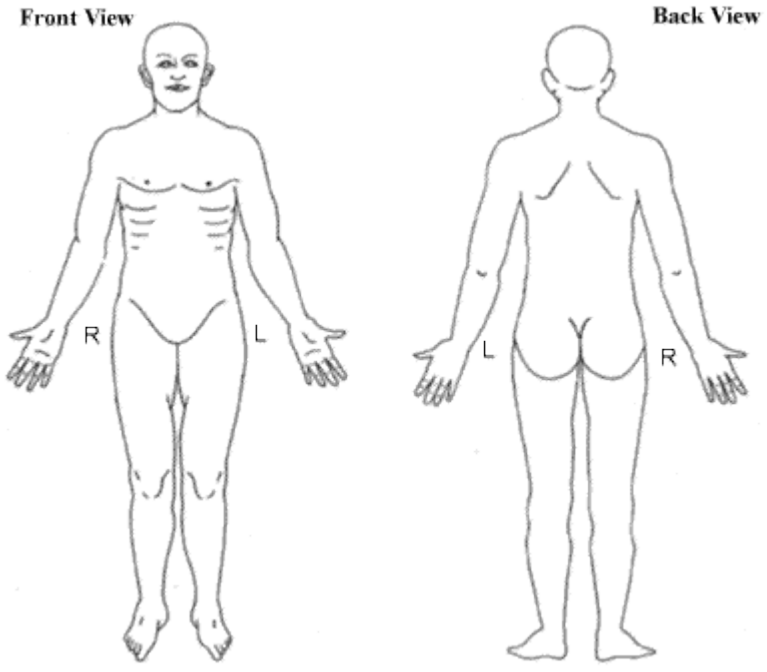
Y N High blood pressure
Y N Hardening of the arteries
Y N Diabetes
Y N Heart or blood vessel disease
Y N Bone spurs on the neck
Y N Whiplash injury
Y N Any relative ever suffer a stroke
Y N Blurred Vision
Y N Double Vision

Have you had any of these following symptoms for even a short or temporary duration within the last year?

Y N Slurred speech or other speech problems
Y N Difficulty swallowing
Y N Dizziness
Y N Temporary lack of understanding
Y N Loss of consciousness or momentary blackouts
Y N Numbness or loss of sensation in face, arms, hands, fingers or legs
Y N Weakness or clumsiness or loss of strength
Y N Diminished or partial loss of vision

IN EVENT OF EMERGENCY:
Who should we contact? _____
Relation: _____
Phone #: _____

Please mark area of your pain. Indicate the degree of pain on a scale of 1(mild) to 10 (severe)



I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that this office will prepare any necessary forms to assist me in making collection from insurance companies they participate with. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to 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 fees for professional and administrational services rendered to me will immediately be due and payable.

Signature: _____
(If patient is a minor, signature of parent/legal guardian is required)