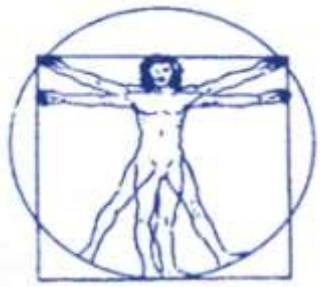
Bound Brook Chiropractic Center DC 222 Hamilton Street Bound Brook, NJ 08805 Phone 732-469-7777

Confidential Patient Case History



Dear Patient:

Please complete this questionnaire. Your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Thank you, Dr. James L. Winters and Staff

Personal Information

Name _____ DOB _____

Address _____ SSN _____

City _____ State _____ Zip_____

Cell (_____)_____ Home (_____)_____ Work (_____)_____

E-Mail _____ Male ☐ Female ☐

Employer _____ Occupation _____

Marital Status S☐ M☐ D☐ W☐ Name of Spouse _____

No. of Children _____ Names and Ages _____

Emergency Contact Name _____ Phone (_____)_____

Who may thank for referring you today? _____

Name of insurance company _____ Policy # _____

Health Information

Reason for you visit today _____

Date of Onset _____ Have you had previous Chiropractic Care? Yes ☐ No ☐

Chiropractor's Name _____ Date of Last Visit _____

Reason for previous Chiropractic Care _____

Have you had this condition before? Yes ☐ No ☐ When? _____

Is your condition related to an auto accident? Yes ☐ No ☐ When? _____

Is your condition related to a work accident? Yes ☐ No ☐ When? _____

Is your condition STAYING THE SAME ☐ GETTING BETTER ☐ GETTING WORSE? ☐

Does your condition interfere with SLEEP ☐ DAILY ROUTINE ☐ WORK ☐ OTHER? ☐

Previous treatment for your condition _____

What makes your condition BETTER? _____

What makes your condition WORSE? _____

Medications you are currently taking: PAIN ☐ DIABETES ☐ HEART ☐ ASPIRIN ☐

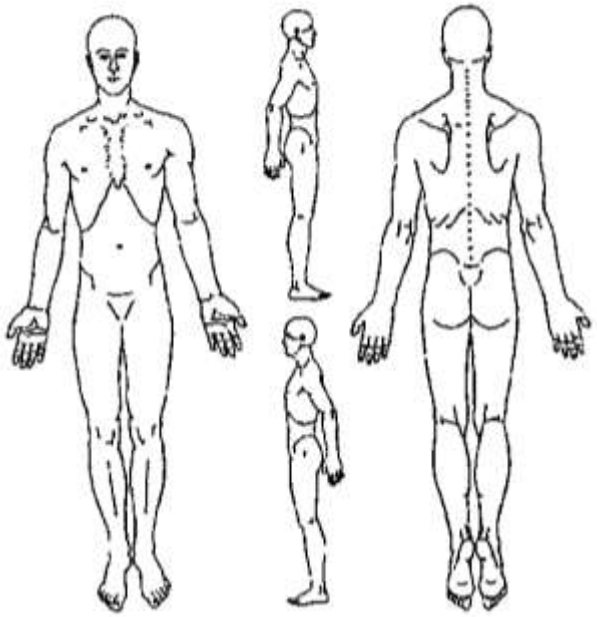
SLEEPING ☐ MUSCLE RELAXER ☐ ANTI-DEPRESSANT ☐ BIRTH CONTROL ☐

Surgeries and Dates _____

Injuries and Fractures and Dates _____

Use the following letters on the diagram to indicate the type of altered sensations you are experiencing.

A=ACHE	**SH=SHARP**
B=BURN	**ST=STABBING**
E=ELECTRIC	**SF=STIFFNESS**
N=NUMBNESS	**TG=TINGLING**
M=MUSCLE SPASM	**TT=TIGHTNESS**



Rate Your Level of Pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Pain

EXERCISE: None ☐ 1-3 Times/Week ☐
3-5 Times/Week ☐ 5-7 Times/Week ☐

Check any of the following conditions you have presently or have had in the past:

☐ Allergies	☐ Digestive Trouble
☐ Anemia	☐ Dizziness
☐ Arthritis	☐ Female Problems
☐ Asthma	☐ Headaches
☐ Back Pain	☐ Heart Disease
☐ Cancer	☐ Male Problems
☐ Chest pain	☐ Menstrual Cramps
☐ Confusion	☐ Mental Disorder
☐ Depression	☐ Multiple Sclerosis
☐ Diabetes	☐ Neck Pain
☐ Epilepsy	☐ Nervousness
☐ Fatigue	☐ Prostate Trouble
☐ Foot Pain	☐ Respiratory Trouble
☐ Ankle Pain	☐ Scoliosis
☐ Knee Pain	☐ Sinus Problems
☐ Hip Pain	☐ Skin Problems
☐ Hand Pain	☐ Stress
☐ Wrist Pain	☐ UTI
☐ Elbow Pain	☐ Weight Gain/Loss
☐ Shoulder Pain	Other _____

DIET: Does your diet include the following?

Fast Food	Yes ☐ No ☐
Food Craving	Yes ☐ No ☐
Fruits	Yes ☐ No ☐
Red Meat	Yes ☐ No ☐
Sweets	Yes ☐ No ☐
Vegetables	Yes ☐ No ☐
Water	Yes ☐ No ☐

Rate Your Diet: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

HABITS: Smoking packs/day _____ **Caffeine** cups/day _____ **Alcohol** amount/day _____ **Soda** oz/day _____

Family Physician Name _____ Date of Last Visit _____

Reason for care _____

Date of Last Physical Exam and by Whom _____

Agreement

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me, the policy holder. I also understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I 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 that any fess for professional services rendered me will be immediately due and payable.

Patient's Signature_____ Date _____

Parent or Guardian Signature_____ Date _____