

Phoenician Health Group

Case History/Patient Information

Doctor _____

3244 E. Indian School Rd Phoenix 85018
 4845 E. Thunderbird Rd. Suite 4 Scottsdale 85254

Please PRINT clearly

General Information

Name: _____ Date: _____

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

Home Phone: _____ Work Phone: _____ E-mail _____

Social Security # _____ Date of Birth: _____ Age: _____ Sex: Female Male

Marital Status Single Married Divorced Widowed Do you have any children? yes no how many? _____

Employer _____ Occupation _____

How did you hear about us? _____

Primary Care Physician Name and Phone _____

Have you ever had Chiropractic care before? yes no If yes, when was your last treatment? _____

May we contact your medical doctor to inform them of your exam results and treatment plan? yes no

Complaint History

1. Describe your current complaint and how the problem began: auto accident other accident work related
explain: _____ gradual sudden no specific reason

2. How long have you had this problem? _____

3. Have you ever had this problem or a similar problem before? yes no When? _____

4. How would you describe your present complaint/pain?

sharp soreness throbbing tingling dull stiffness
 spasm burning ache weakness numbness shooting

5. How often is the pain present?

constant (81-100%) frequent (51-80%) occasional (26-50%) intermittent (25% or less)

6. Since your problem began, is the pain: getting worse getting better Staying the same

7. What makes your problem better?

nothing walking standing sitting activity/exercise lying down inactivity

8. What makes your problem worse?

nothing walking standing sitting activity/exercise lying down inactivity

9. How would you rate the intensity of your pain? (circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10
(no pain) (moderate pain) (unbearable pain)

10. How would you rate your commitment to your health? (circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10
(low) (moderate) (high)

11. Are you currently taking any medications, herbs, vitamins, and/or nutritional supplements?

yes no if yes, please describe: _____

Are you interested in personalized nutritional recommendations? yes no

12. Have you ever been treated for this same problem? yes no If yes, by whom? MD Chiropractic
 What were the approximate dates, type of treatment and the results? _____

13. What is your level of physical activity/exercise ?

- Heavy (5-7 days/wk) Moderate (3-4 days/wk) Light (1-2 days/wk) None
 cardiovascular stretching strength training sports _____

13. How are your eating habits? Professionally recommended diet Good Fair Poor
 Are you interested in having a nutritional analysis/consultation? yes no

14. What is your present general stress level: High Moderate Minimal None

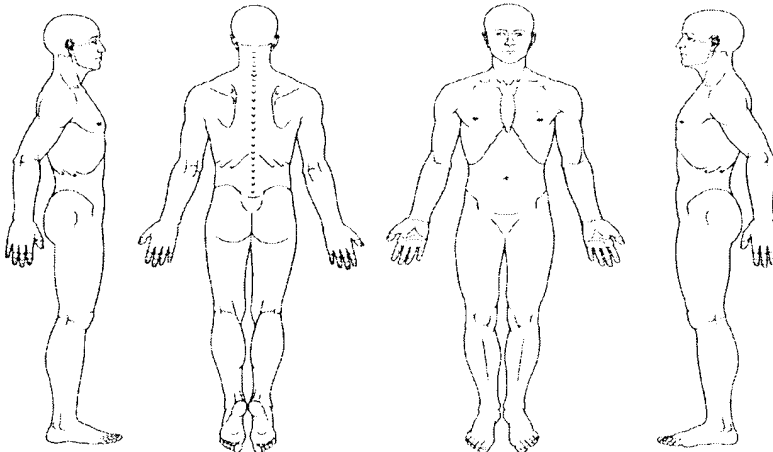
Past or Present Symptoms/Conditions

Below is a list of symptoms and conditions. Please check the box indicating whether this applies to the past or present.

	past present			past present		
Neck pain.....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use:
Shoulder pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> past <input type="checkbox"/> present
Arm/elbow pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> occasional
Hand pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> moderate <input type="checkbox"/> heavy
Upper back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use:
Lower back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> past <input type="checkbox"/> present
Hip/thigh pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> occasional
Knee/leg pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Skin condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> moderate <input type="checkbox"/> heavy
Ankle/foot pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine use:
Jaw pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> past <input type="checkbox"/> present
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies_____			<input type="checkbox"/> occasional
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries_____			<input type="checkbox"/> moderate <input type="checkbox"/> heavy

Family History _____

Using the figures below, please shade in the areas where you have pain or any other symptoms.



Consent for Treatment

I hereby authorize the treating physician and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to be paid directly to the treating physician for services rendered.

Patient's Signature

Date _____

Guardian's Signature (if minor)

Date _____