

# COMEAU HEALTH CARE ASSOCIATES, PC

Wayne A. Comeau, DC, DACBOH

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194 NORTH STREET

DANVERS, MA 01923-1242

## *Patient Case History*

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**A thorough case history is an important part of evaluating your condition and arriving at a diagnosis. Please fill out this form in as much detail as possible. The doctor will review the history with you and answer any questions you might have.**

**Please note that some questions on this form are required by Medicare.**

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### *Personal Data*

Today's Date: \_\_\_\_\_

Patient Title:  Mr  Mrs  Ms  Miss  Dr  Prof  Rev

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_ Suffix \_\_\_\_\_

Nickname: \_\_\_\_\_ Gender:  Male  Female  Unspecified

Marital Status:  Married  Single  Widowed  Other

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Best Number to confirm appointments?  Home  Cell  Work

E-Mail address: \_\_\_\_\_

Verification question: **(Choose only one question by circling the question, then give the answer to that question.)**

What is the name of your favorite pet?  In what city were you born?  What high school did you attend?  What is the name of your favorite movie?  What is your mother's maiden name?

On what street did you grow up?  What was the make of your first car?  What is your anniversary?

Answer to Verification Question: \_\_\_\_\_

Employment Status:  Employed  FT Student  PT Student  Other

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Number of hours a week you work? \_\_\_\_\_

Are you currently able to work?  Yes  No If no, list dates out of work: \_\_\_\_\_

Race (check one)

White  Asian  Japanese  Samoan  Black/African American  
 Asian Indian  Korean  Guamanlan or Chamorro  Hispanic  
 Chinese  Vietnamese  American Indian/Alaskan Native  Filipino  
 Native Hawaiian or other Pacific Island  Other \_\_\_\_\_  
 I choose not to specify

Multi Racial (check one)  Yes  No  Unknown

Ethnicity (check one)

Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (check one)

English  Spanish  American Sign Language  Chinese  French  German  Tagalog  
 Vietnamese  Italian  Korean  Russian  Polish  Arabic  Portuguese  Japanese  
 French Creole  Greek  Hindi  Persian  Urdu  Gujarati  Armenian  I choose not to specify

Date of Your Last Physical Examination: \_\_\_\_\_

In case of emergency please contact \_\_\_\_\_ Phone: \_\_\_\_\_

Are you:  right handed  left handed  ambidextrous

Who referred you to our office? \_\_\_\_\_

Have you seen our advertising? \_\_\_\_\_

Do you currently smoke tobacco of any kind?  Yes  Former Smoker  Never been a smoker  
If yes, how often do you smoke:  Current every day smoker  Current sometimes smoker  
If yes, what is your level of interest in quitting smoking?  
Not at all  0  1  2  3  4  5 Very interested

Current medications, including frequency and dosage if known.

If there are no current medications check here \_\_\_\_\_

1. \_\_\_\_\_ for \_\_\_\_\_ Start date \_\_\_\_\_
2. \_\_\_\_\_ for \_\_\_\_\_ Start date \_\_\_\_\_
3. \_\_\_\_\_ for \_\_\_\_\_ Start date \_\_\_\_\_
4. \_\_\_\_\_ for \_\_\_\_\_ Start date \_\_\_\_\_
5. \_\_\_\_\_ for \_\_\_\_\_ Start date \_\_\_\_\_

List any known allergies you have had to any medications:

If no allergies, check here \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Briefly list your main health problems:

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Has any doctor diagnosed you with Hypertension presently? \_\_\_Yes \_\_\_No

If yes, describe:

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Has any doctor diagnosed you with Diabetes presently? \_\_\_Yes \_\_\_No

If yes, what kind? \_\_\_Type I \_\_\_Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c >9.0%

\_\_\_Yes \_\_\_No \_\_\_Not sure

If yes, other comments regarding Diabetes:

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Have you had an X-ray or CT scan or MRI of your low back in the past 28 days? \_\_\_Yes \_\_\_No

## *Current Complaints*

The pain/problem began on or about: \_\_\_\_\_

The problem is the result of:  Auto accident  Accident at Work  Other

How long have you been having the pain?

1 week or less  1 to 6 weeks  greater than 6 weeks but less than 3 months  
 3 months to 1 year  over 1 year

*Please list your areas of pain in order of severity. .*

1. Area of Pain: \_\_\_\_\_

2. Area of Pain: \_\_\_\_\_

3. Area of Pain: \_\_\_\_\_

4. Other: \_\_\_\_\_

In general my symptoms are better in:  AM  Midday  PM.

In general my symptoms are worse in:  AM  Midday  PM.

symptoms do not change with the time of day.

Do you have night pain unrelated to movement?  Yes  No

Do you have constant pain unrelated to movement?  Yes  No

Are your symptoms / condition:  improving  unchanged  getting worse.

Have you seen specialist(s) for this condition?  Yes  No

Name: \_\_\_\_\_ Location \_\_\_\_\_ Specialty \_\_\_\_\_

Name: \_\_\_\_\_ Location \_\_\_\_\_ Specialty \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

(Guardian If Minor)

**COMEAU HEALTH CARE ASSOCIATES, PC**  
**COMEAU REHAB THERAPIES**

*Wayne A. Comeau, DC, DACBOH*  
Parry N. Comeau, PT, DC  
194 NORTH STREET  
DANVERS, MA 01923-1219

***CONSENT TO PHYSICAL THERAPY SERVICES***

1. I, \_\_\_\_\_,  
authorize the performance upon myself of examinations and/or treatments performed by or under the direction of doctors, associates or assistants employed by Comeau Health Care Associates, PC and or Comeau Rehab Therapies.
  
2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to, or different from those stated above, whether or not arising from presently unforeseen conditions that the doctors, associates or assistants employed by Comeau Health Care Associates, PC and or Comeau Rehab Therapies may consider necessary or advisable in the course of my health care.
  
3. The nature and purpose of the procedures, the possible alternatives, the risks involved, the possible consequences, and the possibility of complication have been explained to me by the doctors, associates or assistants employed by Comeau Health Care Associates, PC and or Comeau Rehab Therapies.
  
4. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the doctors, associates or assistants employed by Comeau Health Care Associates, PC and or Comeau Rehab Therapies.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Witness: \_\_\_\_\_ Relationship: \_\_\_\_\_

# Comeau Health Care Associates

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Parry N. Comeau, P.T., D.C.

194 North Street

Danvers, MA 01923-1219

978-774-5600 Fax – 978-774-5601

To help us with total quality health care for our patients we would like to increase communication between our office and your medical doctor. If you would be interested in our new policy, please complete the authorization form, and we will periodically send an updated report to:

**Primary Care Medical Doctor:** \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

**Other Medical Doctors that need to be informed:** \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

**Patient Please Initial:** \_\_\_\_\_