COMEAU HEALTH CARE ASSOCIATES, PC

Wayne A. Comeau, DC, DACBOH
Parry N. Comeau, P.T., D.C.
100 CONIFER HILL DRIVE, SUITE 205
DANVERS, MA 01923-1242

Patient Case History

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.

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:

_____
_____
_____

Has any doctor diagnosed you with Hypertension presently? ___Yes ___No

If yes, describe:

_____
_____

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:

_____
_____

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
100 CONIFER HILL DRIVE, SUITE 205
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

Wayne A. Comeau, D.C. DACBOH
Parry N. Comeau, P.T., D.C.
100 CONIFER HILL DRIVE, SUITE 205
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: _____