

COMEAU HEALTH CARE ASSOCIATES, PC

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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)

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CONSENT TO CHIROPRACTIC 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.

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 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.

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.

Date: _____ Signed: _____

Witness: _____ Relationship: _____

Comeau Health Care Associates

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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: _____