Dr. Jamie Culhane

The chiropractor for expectant mothers, children and athletes.

Date:

PATIENT INFORMATION:

Name_____
Last First Middle Initial

Home # :_____ Office #: _____
Cell # : _____ Email Address:_____
Address_____
City_____ State_____ Zip_____
SS#_____ Age_____ DOB_____ Sex_____
Marital Status: M S W D Occupation: _____
Employer _____Yrs. Employed_____
Employers Address_____
Spouse's Name_____ Spouse's SS# _____
Spouse's Occupation_____ Spouse's Employer_____
Person responsible for this account? _____ Referred By_____
Have you ever had chiropractic care before? _____ If yes, when?_____

INSURANCE INFORMATION:

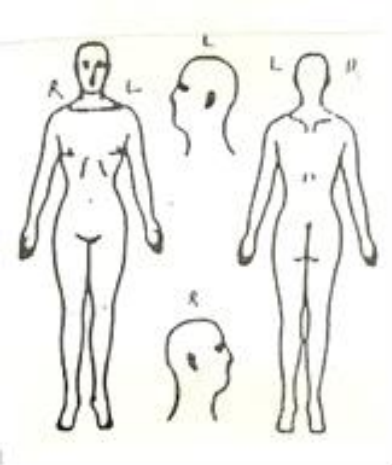
Name of Insurance Company? _____
ID/Policy # : _____ Group #: _____
Ins. Address_____ Tel. #: _____

CASE HISTORY:

List your chief complaints in order of severity:
1._____ For how long?_____
2._____ For how long?_____
3._____ For how long?_____
What activities aggravate your condition?_____
Is this condition getting progressively worse? Yes No Constant Comes and goes
Is this condition interfering with your: Work Sleep Daily routine Other
How long has it been since you really felt good?_____
List other Doctors consulted for this condition:
1._____ Address_____
2._____ Address_____

Are you now or have you recently been in pain? Yes No
If yes, Describe the quality of pain: dull sharp aching stabbing burning throbbing
Does the pain radiate? Yes No down the arms down the legs
Any numbness or tingling? Yes No
Did it come on suddenly or gradually?
Can you pinpoint a specific incident which started the pain?
Rate the pain on a scale of 1 - 10, (10 being unbearable) 1 2 3 4 5 6 7 8 9 10
Have you had any past injuries or accidents? _____ If yes, please list: _____
_____

Have you ever experienced similar pain to which you now have? Yes No
Is there a specific incident which you think caused your condition?_____
Mark the figure below and the location of the pain:



MEDICAL HISTORY: If any of the following are relevant to your medical history, **please circle.**

Cancer	Convulsion	High Blood Pressure	Rheumatism
Polio	Tuberculosis	Muscular Dystrophy	German Measles
Asthma	Concussion	Multiple Sclerosis	Venereal Disease
Anemia	Miscarriages	Backaches	Digestive Disorders
Hepatitis	Diabetes	Headaches	Heart Disease
Toxemia	Placentia Previa	Arthiritis	Osteoporosis

Describe any surgeries you have had: _____
_____
Are you allergic to any medication? _____ If yes, please list: _____
_____
I clearly understand and agree that all services rendered to 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, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. The Doctor will not be held responsible for any pre-exisiting medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature _____Date _____