# 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_____
Telephone #: _____

**CASE HISTORY FOR EXPECTANT MOTHER:**
Date of Last Menstrual Period: _____
Conception Date: _____ Estimated Due Date: _____
Is this your first pregnancy? Yes No Was this pregnancy planned? Yes No
Prior History of Birth Control Method(s): _____
Previous Childbirth Education Classes? Yes No
Are you currently taking Supplements/Vitamins/Medication? _____
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?_____

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List other Doctors consulted for this condition:
1._____ Address_____
2._____ Address_____
Is this injury or illness work-related?___ Have you reported it to your employer?___

Is this injury or illness related to an automobile accident?____ If yes, please complete.
Auto insurance Co._____
Policy #: _____
Date of Injury: _____ Claim #: _____
Agent Name & Phone #: _____
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
Mark the figure below at location of pain:
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? _____
_____
Is there a specific incident which you think caused your condition?_____
_____
Mark the figure below and the location of the pain:

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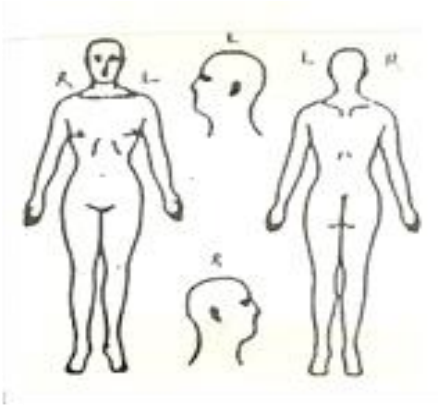

**MEDICAL HISTORY**: If any of the following are relevant to your medical history, **please circle.**

| | | | |
|---|---|---|---|
| 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 | Arthritis | Osteoporosis |

Describe any surgeries you have had: _____

Are you allergic to any medication?_____ If yes, please list _____

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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 _____