



ELANCO CHIROPRACTIC, INC.

1907 Division Highway • Ephrata, PA 17522

Office: 717-355-5000 • Fax: 717-354-8587

www.elancochiropractic.com

Building Healthy Living

Confidential Case History

Today's Date: _____ How did you hear about our office? _____

First Name: _____ MI. _____ Last Name: _____

Home Address: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell phone: _____ - _____ - _____

Male/Female Date of Birth ____/____/____ Age: _____ Email: _____

Marital Status: S / M / D / W No. of Children: _____ Occupation: _____

Employer: _____

Work Phone: _____ - _____ - _____ Employed: Work Full /Part Time, Student Full/Part Time

Spouse: _____ Spouse Occupation: _____ Cell Phone: _____ - _____ - _____

In addition to your spouse, whom should we contact in case of an emergency?

Name: _____ Relationship: _____

Phone: _____ - _____ - _____ Address: _____

MAJOR MEDICAL INSURANCE:

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy #: _____ Group #: _____

Phone: _____ - _____ - _____

Have you been under Chiropractic care before? Yes / No

If yes please describe: _____

Doctor's Name: _____ Date of Last Treatment: ____/____/____

Name of Practice: _____

Practice Phone: _____ - _____ - _____

Please put the appropriate symbol (X) or (O) on the line for any of the following symptoms
NOW have (X) OR **HAD** previously (O)

<p> <input type="checkbox"/> Neck Pain <input type="checkbox"/> Neck Stiffness <input type="checkbox"/> Neck Grating <input type="checkbox"/> Neck Tension <input type="checkbox"/> Mid-back Pain <input type="checkbox"/> Mid-back Stiffness <input type="checkbox"/> Mid-back Grating <input type="checkbox"/> Mid-back Tension <input type="checkbox"/> Low back Pain <input type="checkbox"/> Low back Stiffness <input type="checkbox"/> Low back Grating <input type="checkbox"/> Low back Tension </p> <p><u>Pain in:</u></p> <p> <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Feet </p> <p><u>Numbness in:</u></p> <p> <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Feet </p> <p><u>Other Conditions:</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Do you have any heart conditions? YES / NO Explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Do you any have lung conditions? YES / NO: Explain: _____</p>	<p> <input type="checkbox"/> Painful Tailbone <input type="checkbox"/> Sciatica <input type="checkbox"/> Painful Joints <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Bursitis <input type="checkbox"/> Hernia <input type="checkbox"/> Pinched Nerves <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bad moods and Behavior <input type="checkbox"/> Tremors <input type="checkbox"/> Insomnia <input type="checkbox"/> Sweats <input type="checkbox"/> Chills <input type="checkbox"/> Belching <input type="checkbox"/> Excessive Gas <input type="checkbox"/> Colon Trouble <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Vomiting <input type="checkbox"/> Stomachaches <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Eye Pain <input type="checkbox"/> Ringing in the Ears <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pains <input type="checkbox"/> Poor Circulation </p>	<p> <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Bedwetting <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Kidney trouble <input type="checkbox"/> Prostate Trouble <input type="checkbox"/> Menstrual Cramps <input type="checkbox"/> Excessive Flow <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Pregnancy <input type="checkbox"/> Menopausal Symptoms <input type="checkbox"/> Lumps in Breast </p> <p><u>Conditions:</u></p> <p> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer, Type: _____ _____ _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Disease <input type="checkbox"/> Miscarriage <input type="checkbox"/> Polio <input type="checkbox"/> Stroke <input type="checkbox"/> T.B. <input type="checkbox"/> Ulcers <input type="checkbox"/> Mental Disorders <input type="checkbox"/> Moles (color and/or size change) </p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Current Medications (If possible please provide list): _____

PAST MEDICAL HISTORY:

Surgeries and Dates: _____

Serious Illnesses and Dates: _____

Fractures and Dates: _____

Worker's Compensation Injuries and Dates: _____

Auto Accidents, Dates, Injuries and Treatment: _____

Sports or Other Injuries, Dates and Treatment: _____

FAMILY HISTORY

<u>Relative</u>	<u>Age if Living</u>	<u>Age at Death</u>	<u>Cause of Death</u>	<u>State of Health</u>	<u>Illnesses</u>
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY: Smoke: () None Pack/Day _____ Years _____

Alcohol: () Never () Social () Light () Moderate

What is your Height: _____ Weight: _____ Shoe size: _____ Dominant Hand: Right / Left

History of Onset (Injury)and Date: _____

Please List Major Complaints:

1. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

2. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

3. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

4. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

5. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

Have you ever had the same or similar condition? Yes / No

If yes please describe: _____

Is there anything you can do to relieve the problem? Yes / No

If yes please describe: _____

Have you been treated for any other health condition in the past year? Yes / No

If yes please describe: _____

Name of Primary Care Physician: _____

Primary Care Physician Phone: _____ - _____ - _____

Hospital/Practice location: _____

WOMEN ONLY

Are you pregnant, or is there any possibility that you may be pregnant?

YES / NO

Signature: _____

Authorization and Release:

I authorize payment of insurance benefits directly to ELANCO Chiropractic and Rehabilitation Center, Inc and or the Owner/President of ELANCO Chiropractic Dr. Gary J. Greve. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, Healthcare operations and coordination of care. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctors, any fees for professional services rendered will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

Patient's/Guardians Signature _____ DATE: ____/____/____

Pain Drawing

Use the appropriate symbols shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, and mark the type and area.

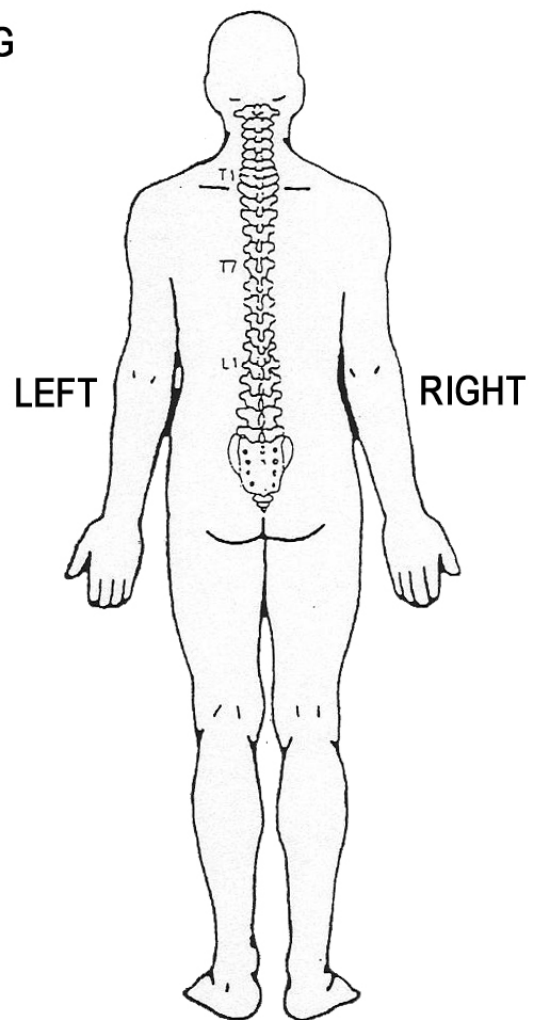
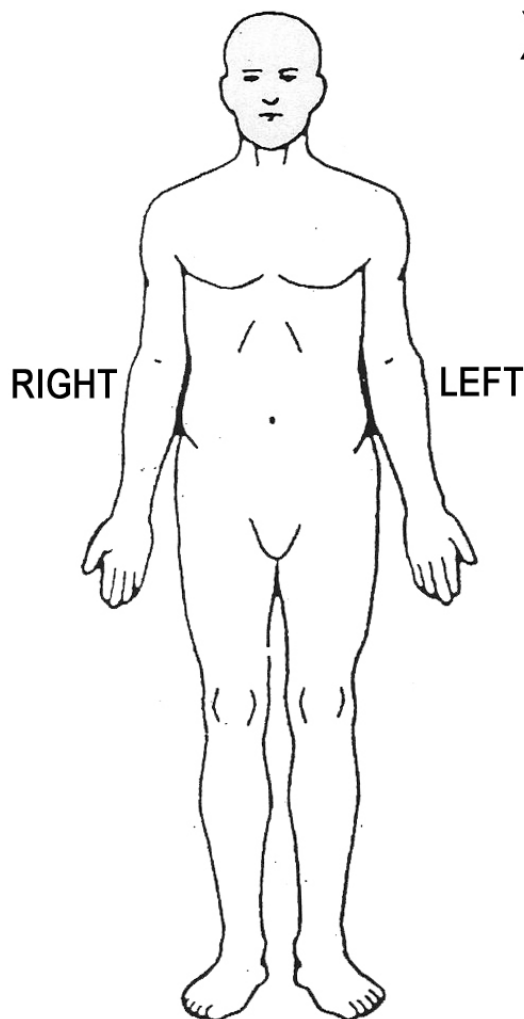
= PINS AND NEEDLES

O NUMBNESS

/ STABBING

X BURNING

^ ACHING



Signature: _____

Date: _____