



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: _____ - _____ - _____

ELANCO CHIROPRACTIC, INC.

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

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 Each Major Complaints: (ex: neck, back, shoulder, etc.)

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)

ELANCO CHIROPRACTIC, INC.

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.

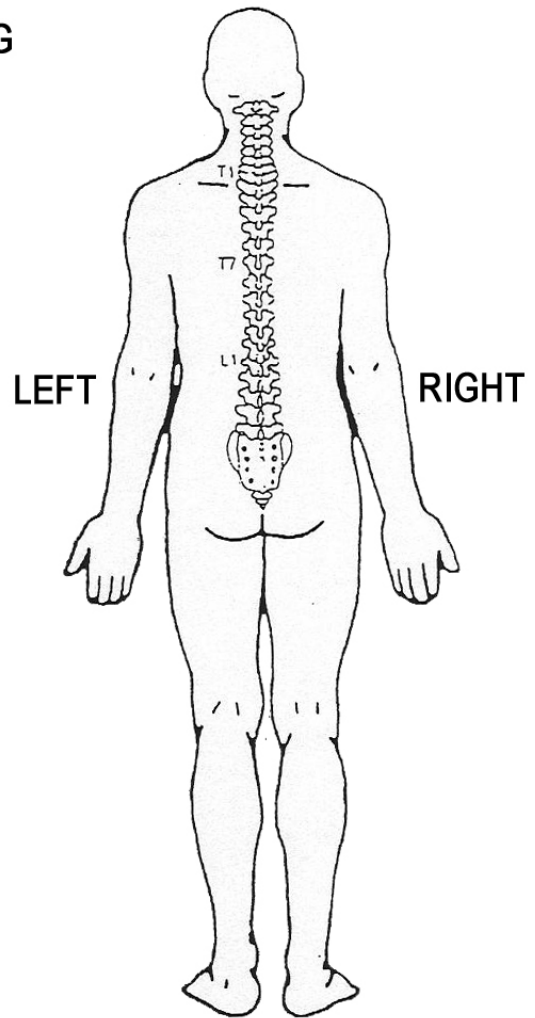
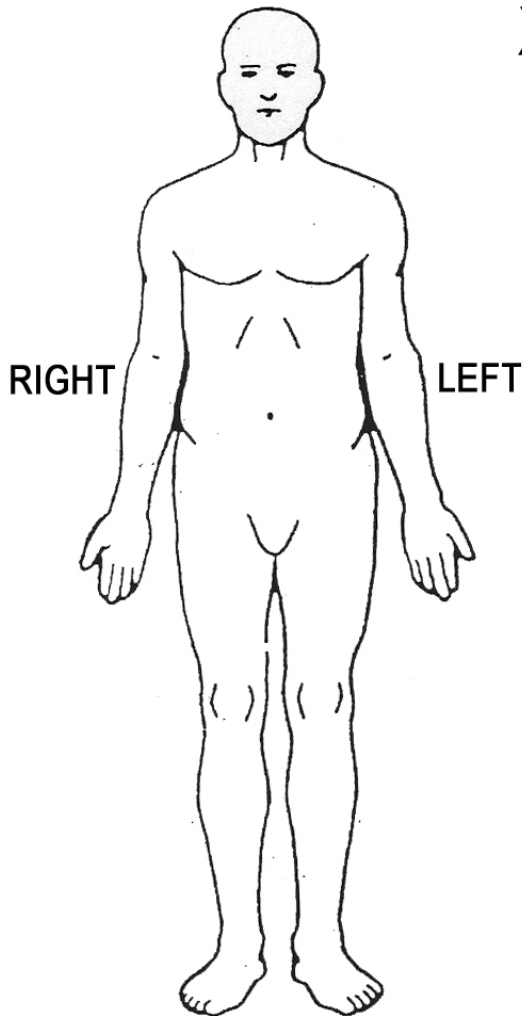
= PINS AND NEEDLES

O NUMBNESS

/ STABBING

X BURNING

^ ACHING



Signature: _____

Date: _____