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: _____

First Name: _____ MI._____ Last Name: _____

Home Address: _____City: _____ 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: _____

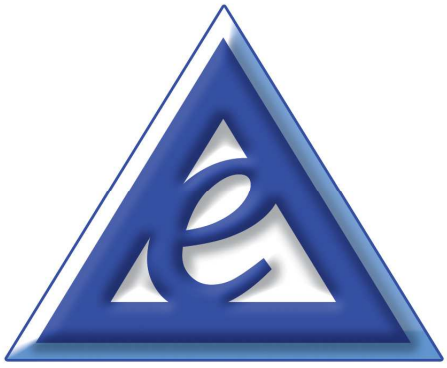
Practice Phone: _____-_____-_____

Patient Name: _____ Date: _____

How did you hear about our office?

Please check all that apply

- ☐ Doctor : Name? _____
- ☐ Presentation
- ☐ Expo : Name? _____
- ☐ Postcard/letter
- ☐ Newsletter
- ☐ Newspaper
- ☐ Hometown Values Mag.
- ☐ Phonebook
- ☐ Internet Search
- ☐ ELANCO Website
- ☐ Facebook
- ☐ Staff : Name? _____
- ☐ Patient : Name? _____
- ☐ Care Enough to Share Card



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

___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

Pain in:
___Shoulders
___Arms
___Hands
___Hips
___Legs
___Feet

Numbness in:
___Shoulders
___Arms
___Hands
___Hips
___Legs
___Feet

Other Conditions:
_____
_____
_____
_____

Do you have any heart conditions?
YES / NO Explain:
_____
_____
_____
_____

Do you any have lung conditions?
YES / NO:
Explain:_____

___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

___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

Conditions:
___Alcoholism
___Anemia
___Arteriosclerosis
___Arthritis
___Cancer,
Type:_____
_____
_____
___Diabetes
___Drug Abuse
___Epilepsy
___Heart Disease
___Miscarriage
___Polio
___Stroke
___T.B.
___Ulcers
___Mental Disorders
___Moles (color and/or size change)
_____
_____

Other: _____
_____
_____
_____
_____

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

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
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

ELANCO CHIROPRACTIC, INC.

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)

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.

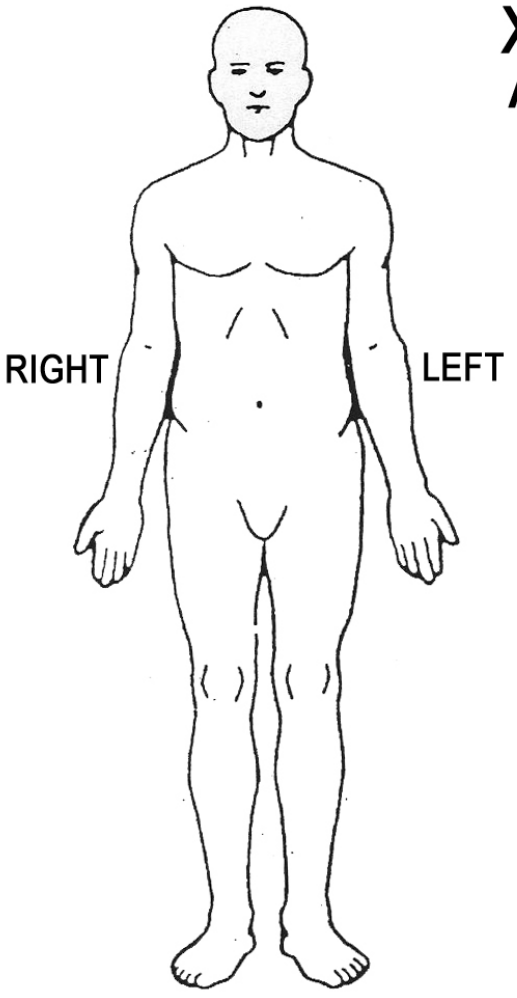
= PINS AND NEEDLES

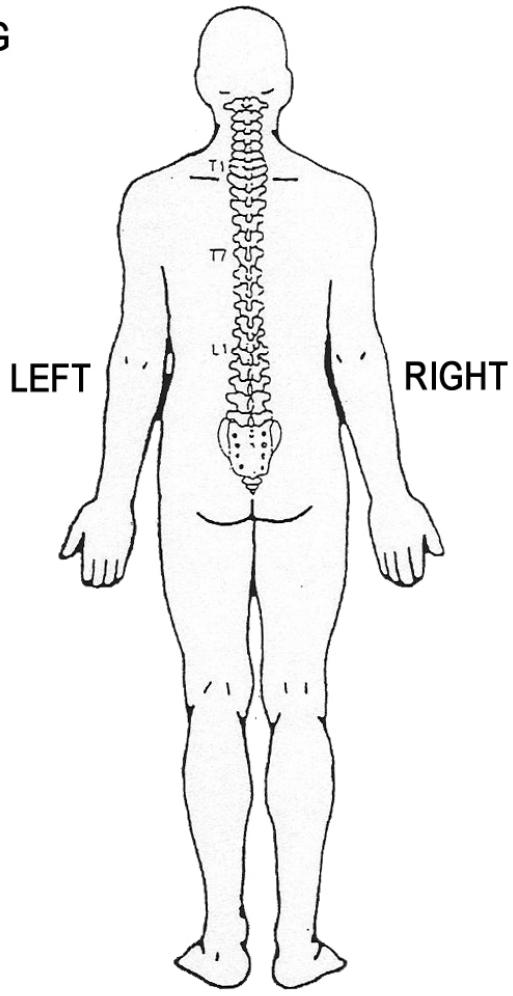
O NUMBNESS

/ STABBING

X BURNING

∧ ACHING





Signature: _____ Date: _____