Patient Name____________________________ **Date** ____________ **Patient Number**____________

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history must be completed before treating in our office and will be part of your permanent records. Please answer questions completely and to the best of your knowledge. THANK YOU.

Name ____ Birthday ____/____/____ Soc Sec #____-___-_____
Last First MI

Address ____
Street City State Zip

Home Phone (____) ____-________ Work (_____) ____-________ Cell (_____) ____-________

Sex ☐M ☐F Marital Status: ☐M ☐S ☐D ☐W Chief Complaint________________________________

Occupation ________________________________Employer____

Insurance Company__________________________Name/Relationship of Insured_________________________

ID/Member #______________________________Insurance Phone #___________________________________

Who may we thank for referring you? How did you hear about us?______________________________________

Would you like us to send you monthly health topics by email? NO / YES (email___________________________)

Spouse/Parent Name______________________________Birthday____/____/______ Soc Sec #____-___-_____

Spouse/Parent Employer______________________________ Emergency Phone# (_____) _____-__________.

Do you have any children? NO / YES (Names & Ages____)

Are your present symptoms or conditions related to or the result of an auto accident, work related injury or other personal injury someone else might be responsible for? NO / YES (If yes, date of injury____/____/____)
Have you been in any auto accidents, work injuries, falls or had any other significant personal injury?
NO / YES (Give Explanation &Dates) ____
____
____

What is the condition/problem you are concerned with? ____
____
When did it start? _______________________________What caused it?_____________________________________
Have you had the same/similar conditions in the past? NO / YES (When___________________________________)
Type of Pain: Dull / Sharp / Numbness / Tingling / Stiffness / Burning / Throbbing / Shooting / Achy
Does the Pain: Come and Go/Constant/Other ___________ Is the condition: Improved/Unchanged/Getting Worse
Has your condition affected your daily activities? NO / YES (Explain______________________________________)
Do any positions/activities make it feel better?____
What have you tried to alleviate symptoms?____
Other doctors or therapists who have treated THIS condition ____
Are you currently taking any medications for this condition? NO / YES (__________________________________)

Have you had any surgeries in the past or are you scheduled for any surgeries in the future?
NO / YES (Give Procedure & Dates) ____
____
Date of Last Spinal X-Ray ___________ Taken at ________________________________ ☐ Normal ☐ Abnormal
Any Known Allergies? NO / YES ____

Family Physician__________________________Hospital/Clinic____

SOCIAL HISTORY Check the boxes and fill in.

Current Weight ____________ Have you recently lost or gained weight? ______________________________

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day ____________

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day ____________

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week ___________ Type _____________________

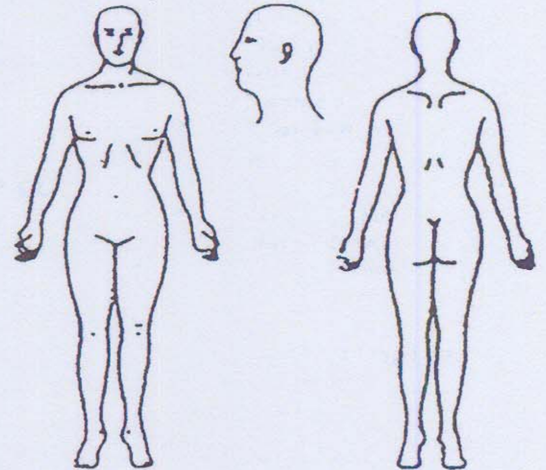
Smoking ☐ Current ☐ Previous Packs/Day ______ No. of years ______

Alcohol Beer/Week ______ Liquor/Week ______ Wine/Week ______ No. of Years ______

Caffeine *(Coffee, Tea, Cola)* Cups/Day _______ No. of Years ______

Aspirin No./Day ______ No. of Years ______ Others ____________________________________

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.



Use the appropriate letter shown for each symptom:

Aches–A Burning-B Pins/Needles-P

Cramps-C Stabbing -S Numbness-N

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)________

Legal Assignment & Financial Responsibility

I, the undersigned certify that I (or my dependent) have provided A. Unruh Chiropractic with any and all information necessary to bill all insurance claims for myself, and not providing this information forfeits my ability to have claims sent on to my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I will notify A. Unruh Chiropractic of any and all changes to my insurance company or plan before I receive treatment after the time that this information has changed. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submission. I also assign to A. Unruh Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services from such doctor and clinic. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

After evaluation by Dr. Allen Unruh, he and his staff have explained to me that some of the services that have been prescribed to me and I might choose to receive, may not be a covered benefit as defined by my health insurance policy or certificate. I understand that insurance companies do not pay for services that are not deemed medically necessary. However, I may still choose to receive these services (ex. Hydro, laser, supplements, and supplies). I understand and acknowledge that if I do choose to receive such items, I will be responsible for these items as well as any applicable deductible, co-pay, or coinsurance at the time of service unless prior arrangements were made.

____ ________________

Signature of Patient/Insured/Guardian Date

CHECK ONLY THE ONES YOU HAVE NOW OR HAVE HAD IN THE PAST!!

GENERAL	Now	Past
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	______	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	Now	Past
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	Now	Past
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐
Contraception Type ____________		
Menstrual Flow ☐Hvy ☐Lt ☐Mod		
Last Period ____________		
Last Pap Smear ____________		
Last Mammogram ____________		
Last Prostate Exam ____________		

NEUROLOGIC	Now	Past
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Incoordination	☐	☐
Loss of Sensation	☐	☐
Loss of Facial Control	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speaking	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐
ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐
MUSCULOSKELETAL		
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐
PSYCHIATRIC		
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Undecidedness	☐	☐
Irritable	☐	☐
Extreme Worry	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐

PAST MEDICAL HISTORY-Check if you've had in the PAST!

Allergies	☐	Heart Trouble	☐	Dysentery	☐	Stroke	☐
Alcoholism	☐	Blood Disease	☐	Hepatitis	☐	Cancer	☐
Depression	☐	Varicose Veins	☐	Gallstones	☐	Ulcers	☐
Epilepsy	☐	Kidney Stones	☐	Leukemia	☐	Polio	☐
Paralysis	☐	Kidney Infections	☐	Liver Trouble	☐	Mumps	☐
Angina	☐	Nervous Breakdown	☐	Diabetes	☐	Tumor	☐
Migraine	☐	Bladder Trouble	☐	Hypertension	☐	Jaundice	☐
Phlebitis	☐	Prostate Problems	☐	Mental Illness	☐	Parasites	☐
Hay Fever	☐	Rheumatic Fever	☐	Skin Trouble	☐	Gout	☐

FEMALES ONLY: I understand that if I'm pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered safe for x-ray exams.

- I am currently Pregnant YES / NO   - I could be Pregnant YES / NO   -I am late with my menstrual period YES / NO

With Full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed now.

Signature____ **Date**________________

Patient Name________________________Date __________Patient Number__________

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history must be completed before treating in our office and will be part of your permanent records. Please answer questions completely and to the best of your knowledge. THANK YOU.

Name ____Birthday ____/____/_____ Soc Sec #____-___-_____
Last First MI

Address ____
Street City State Zip

Home Phone (___) ____-________ Work (____) ____-________ Cell (_____) ____-__________

Sex M F Marital Status: M S D W Chief Complaint_______________________________________

Occupation ________________________________Employer____

Insurance Company___________________________Name/Relationship of Insured__________________________

ID/Member #________________________________Insurance Phone #____________________________________

Who may we thank for referring you? How did you hear about us?____

Would you like us to send you monthly health topics by email? NO / YES (email______________________________)

Spouse/Parent Name_________________________________Birthday____/____/______ Soc Sec #____-___-_____

Spouse/Parent Employer____________________________ Emergency Phone# (_____) _____-__________.

Do you have any children? NO / YES (Names & Ages____)

Are your present symptoms or conditions related to or the result of an auto accident, work related injury or other personal injury someone else might be responsible for? NO / YES (If yes, date of injury____/____/_____)
Have you been in any auto accidents, work injuries, falls or had any other significant personal injury?
NO / YES (Give Explanation &Dates) ____
____
____

What is the condition/problem you are concerned with? ____
____

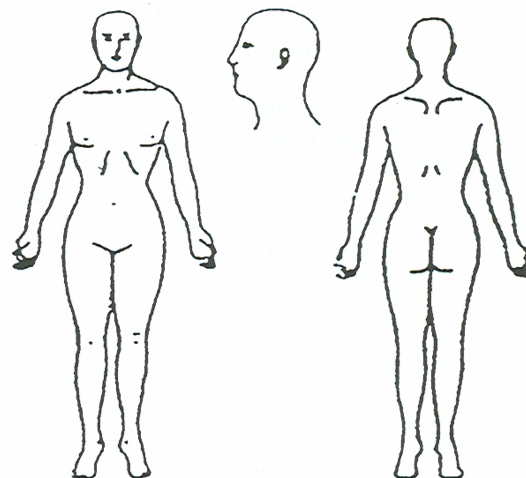
When did it start? _______________________________What caused it?______________________________________
Have you had the same/similar conditions in the past? NO / YES (When_______________________________________)
Type of Pain**:** Dull / Sharp / Numbness / Tingling / Stiffness / Burning / Throbbing / Shooting / Achy
Does the Pain: Come and Go/Constant/Other ___________ Is the condition: Improved/Unchanged/Getting Worse
Has your condition affected your daily activities? NO / YES (Explain____)
Do any positions/activities make it feel better?____
What have you tried to alleviate symptoms?____
Other doctors or therapists who have treated THIS condition ____
Are you currently taking any medications for this condition? NO / YES (____________________________________)

Have you had any surgeries in the past or are you scheduled for any surgeries in the future?
NO / YES (Give Procedure & Dates) ____
____
Date of Last Spinal X-Ray ___________ Taken at _________________________________ Normal Abnormal
Any Known Allergies? NO / YES ____

Family Physician___________________________Hospital/Clinic____

SOCIAL HISTORY Check the boxes and fill in.
Current Weight _____________ Have you recently lost or gained weight? _________________________________
Mental Work Heavy Moderate Light Hours per day _____________
Physical Work Heavy Moderate Light Hours per day _____________
Exercise Heavy Moderate Light Hours per week ____________ Type ______________________
Smoking Current Previous Packs/Day _______ No. of years ______
Alcohol Beer/Week ______ Liquor/Week ______ Wine/Week ______ No. of Years ______
Caffeine *(Coffee, Tea, Cola)* Cups/Day _______ No. of Years ______
Aspirin No./Day ______ No. of Years ______ Others ____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.



Use the appropriate letter shown for each symptom:
Aches–A Burning-B Pins/Needles-P
Cramps-C Stabbing -S Numbness-N

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)_________

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I, the undersigned certify that I (or my dependent) have provided A. Unruh Chiropractic with any and all information necessary to bill all insurance claims for myself, and not providing this information forfeits my ability to have claims sent on to my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I will notify A. Unruh Chiropractic of any and all changes to my insurance company or plan before I receive treatment after the time that this information has changed. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submission. I also assign to A. Unruh Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services from such doctor and clinic. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

After evaluation by Dr. Allen Unruh, he and his staff have explained to me that some of the services that have been prescribed to me and I might choose to receive, may not be a covered benefit as defined by my health insurance policy or certificate. I understand that insurance companies do not pay for services that are not deemed medically necessary. However, I may still choose to receive these services (ex. Hydro, laser, supplements, and supplies). I understand and acknowledge that if I do choose to receive such items, I will be responsible for these items as well as any applicable deductible, co-pay, or coinsurance at the time of service unless prior arrangements were made.

____ ___________________
Signature of Patient/Insured/Guardian Date

CHECK ONLY THE ONES YOU HAVE NOW OR HAVE HAD IN THE PAST!!

GENERAL Now Past
- Weakness
- Fatigue
- Fever
- Chills
- Night Sweats
- Fainting

SKIN
- Color Changes
- Nail Changes
- Hair Changes
- Moles
- Rashes
- Sores
- Weakness

HEAD
- Headaches
- Injuries
- Bumps
- Last Eye Exam ______
- Glasses
- Contacts
- Cataracts

EARS
- Hard of Hearing
- Deafness
- Ringing
- Discharge
- Earache
- Itching
- Dizziness
- Room Spins

NOSE
- Decreased Smell
- Bleeding
- Pain
- Discharge
- Obstruction
- Post Nasal Drip
- Deviated Septum
- Runny Nose
- Sinus Congestion

MOUTH
- Bleeding Gums
- Sores
- Dental Problems
- Bad Breath
- Loss of Taste
- Dry Mouth
- Ulcers
- Blisters

THROAT Now Past
- Soreness
- Bad Tonsils
- Hoarseness
- Pain
- Trouble Swallowing
- Recurrent Infections

NECK
- Neck Enlargement
- Stiff Neck
- Soreness
- Lumps
- Masses

BREASTS
- Discharge
- Lumps
- Pain
- Bleeding
- Nipple Changes
- Skin Changes
- Bloated

LUNGS
- Cough
- Phlegm
- Blood
- Short of Breath
- Wheezing
- Pain
- Congestion
- Inhalant Exposure

HEART
- Murmur
- Palpitations
- Rapid Heartbeat
- Swollen Extremities
- Cold Extremities
- Chest Pain/Pressure
- Varicose Veins
- Blood Clots
- Blue Extremities

BLOOD
- Anemia
- Low Blood Iron
- Easy Bruising
- Easy Bleeding
- Swollen Nodes
- Painful Nodes
- Sugar in Blood
- Red Spots

GASTROINTESTINAL Now Past
- Abdominal Pain
- Nausea
- Bloated
- Belching
- Heartburn
- Indigestion
- Irregular Bowel Habits
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Poor Appetite
- Food Intolerance
- Bloody Stools
- Black Stools

GENITOURINARY
- Urgency
- Incontinence
- Straining
- Back Pain
- Frequent Voiding
- Stones
- Burning
- Bed Wetting
- Small Stream
- Discharge
- Impotence
- Dribbling
- Cloudy Urine
- Spotting Between Periods
- Menstrual Cramps
- Discharge
- Itching
- Painful Intercourse
- Irregular Periods
- Hot Flashes
- Contraception Type ______________
- Menstrual Flow Hvy Lt Mod
- Last Period ______________
- Last Pap Smear ______________
- Last Mammogram ______________
- Last Prostate Exam ______________

NEUROLOGIC Now Past
- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Incoordination
- Loss of Sensation
- Loss of Facial Control
- Weak Grip
- Paralysis
- Difficulty Speaking
- Tingling
- Loss of Memory
- Numbness

ENDOCRINE
- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

MUSCULOSKELETAL
- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain

PSYCHIATRIC
- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Undecidedness
- Irritable
- Extreme Worry
- Hallucinations
- Loss of Memory
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- Drug Addiction
- Drug Dependent
- Suicidal Thoughts

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Allergies	Heart Trouble	Dysentery	Stroke
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Paralysis	Kidney Infections	Liver Trouble	Mumps
Angina	Nervous Breakdown	Diabetes	Tumor
Migraine	Bladder Trouble	Hypertension	Jaundice
Phlebitis	Prostate Problems	Mental Illness	Parasites
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- I am currently Pregnant YES / NO - I could be Pregnant YES / NO -I am late with my menstrual period YES / NO

With Full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed now.

Signature____ **Date**__________________

WORKER COMPENSATION INFORMATION

Date________________________________

PATIENT INFORMATION

Name________________________________ Birthdate________________ Soc. Sec. #________________

Address____

____

Telephone________________________________ Occupation________________________________

EMPLOYER

Employer Name____

Employer Address____

____

Employer Telephone________________________________ Injury Verified By (For Office Use)________________

Contact Person____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier____

Carrier Address____

____

Carrier Phone Number________________________________ Coverage Verified by________________________________

Adjuster's Name________________________________ Claim Number________________________________

INJURY INFORMATION

Date of Injury________________________________ Time________________ ☐ AM ☐ PM

Place of Injury____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to________________________________

Give full description of how accident happened____

____

____

____

____

Have you lost time from work? ☐ Yes ☐ No How much?________________________________

Other doctors seen for this condition:

Doctor's Name________________________________ Diagnosis________________________________

Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s)____

____

____

____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries________________________________

Describe previous Worker Compensation injuries____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature________________________________ Date________________