



REEF CHIROPRACTIC CARE

Dr. Brian C. Baker • Chiropractic Physician • 133 Reef Road • Fairfield, CT • Phone: 203.259.4939

Confidential Patient Case History

Name: _____	Social Security #: _____	Age: _____	Birth date: _____
Address: _____	City: _____	State: _____	Zip Code: _____
Home Phone: _____	Work Phone: _____	Marital Status: M S W D # children: _____	
Occupation _____	Employer _____	Spouse's Name _____	
Spouse's work phone: _____	Referred by: _____		
E-Mail address _____	Have you had previous chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Current Health Condition

What is your major complaint? _____

Is condition: Job Related Auto Accident Home Injury Fall other _____

If work or auto injury what was the date and time of injury _____ Reported to employer? Yes No

How long have you had this condition? _____ Have you had this or a similar condition in the past? Yes No

Is the condition getting progressively worse? Yes No Constant Comes and goes

Is sleep affected? Yes No Age of mattress: _____ Is it comfortable? Yes No Female: Are you pregnant? Yes No

What activities aggravate your condition? _____

Other doctors seen for this condition? Yes No Who? _____ Type of treatment _____

Drugs you now take: Nerve pills Painkillers Muscle Relaxers Blood Pressure pills Insulin Birth control pills
 Vitamin supplements Others: _____

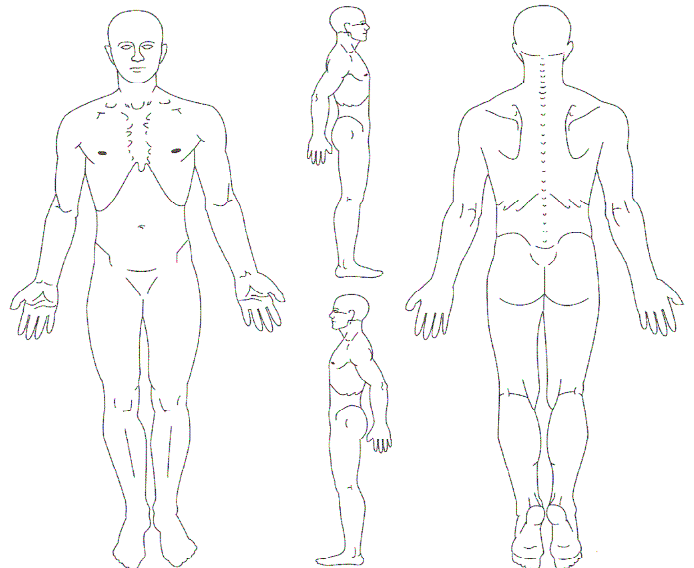
Do you wear: heel lifts orthotics arch supports

Name and address of your primary care physician _____

May we send them a report on your evaluation and treatment with this office? Yes No

On the diagram to the right, outline the area of your pain or discomfort:

Health Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____



Please turn over and complete the back of this form →

Past Health History

Please be as complete as possible. All information is confidential.

List surgical operations and years: _____

Family who have/had similar problems as yours: Mother Father Brother Sister Spouse Children

Have you ever had an: Auto accident? Sports Injury? Household Accident? Work Injury? Personal Injury?

If so please describe: _____

Have you ever been hospitalized? _____ Ever broken any bones? _____

Check any of the following you have **EVER** had:

- | | | | | | | |
|---|--------------------------------------|------------------------------------|--|------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Mental disorders | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio |

Have you ever **tested** HIV positive? Yes No

Check any of the following you have had in the past **YEAR**.

Muscular-skeletal

- Low Back Pain
- Neck Pain
- Joint Pain/Stiffness
- Difficulty Chewing
- Clicking Jaw
- Stiffness
- Foot Trouble
- Leg Pain

General

- Fatigue
- Allergies
- Headaches
- Fever
- Loss of Sleep

Nervous System

- Nervous
- Numbness
- Forgetfulness
- Fainting
- Convulsions
- Cold Tingling Extremities

EENT

- Nose Bleeds
- Vision Problems
- Ear Aches
- Sinus Problems
- Hearing Difficulty
- Sore Throat
- Dental Problems

Gastro-Intestinal

- Poor/Excessive Appetite
- Excessive Thirst
- Diarrhea
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Heartburn
- Gas/Bloating After Meals
- Colitis

Genito-Urinary

- Kidney Stones
- Bladder Problems
- Painful/Excessive Urination
- Prostate Problems

Cardiovascular

- Chest Pain
- Shortness of Breath
- Heart Problems
- High Blood Pressure
- Ankle Swelling
- Stroke
- Varicose Veins
- Menstrual Irregularities
- Breast Pain/Lumps
- Menstrual Cramps/Backaches
- Yeast Infections

Insurance Information

Do you have Health Insurance? Yes No If yes, Insurance Company _____

Policy #: _____ Insured _____

Are you covered under Medicare? Yes No If yes, Medicare ID #: _____

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Reef Chiropractic Care will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Reef Chiropractic Care will be credited to my account on receipt. However, 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 me will be immediately due and payable.

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature: _____ Date _____