PATIENT INFORMATION/CASE HISTORY

Craig A. Robin, D.C.

Date: ______________

PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

City: ______________ State: _____ Zip: __________

Home Phone: ______________ Cell: ______________

Date of Birth: _____ / _____ / ________

Age: _____ Gender: M F SS#: ______________

Occupation: ______________________________

Employer: ______________________________

Family/Medical Doctor: ______________________

Emergency Contact: ______________ Ph: ________

How were you referred to our office?

____

Have you been to a chiropractor before? Y N

If yes, who? ______________________________

How long ago? ______________________________

INSURANCE INFORMATION

☐ Medicare

☐ Group Insurance

☐ Private Insurance

☐ Other: ______________________

Insurance Company: ______________________

Policyholder: ______________________

I, the undersigned, hereby assign all benefits otherwise payable to me for services rendered at the office of Craig A. Robin, D.C., to Dr. Dr. Craig A. Robin. I understand I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits from my insurance.

X ______________________________

Relationship to patient: ______________________

PATIENT CASE HISTORY

1. Please describe your problem/condition:

   ____

2. What does this prevent you from doing or enjoying? ______________________
3. How did it originally occur? Auto Accident__ Work Accident__ Illness__ Unknown__
   Other:____
4. Have you ever had this pain/problem before? Y N Explain: ______________________
5. When did this problem start? ______________ How long does it last? ______________
6. How frequent is the problem? Constant___ Daily___ Comes and Goes___ Night Only___
7. Describe the nature of the pain/problem: Sharp___ Stabbing___ Dull___ Achy___ Tingling___
   Burning___ Numbness___ Radiating___ Swelling___ Other: ______________________
8. Is this problem: Getting Better___ Getting Worse___ About the Same___ Gradually Worse___
9. What makes the pain/problem worse? Standing___ Sitting___ Lying___ Bending___ Lifting___ Twisting___
   Other: ____
10. Is there anything you can do to relieve the pain/problem? Y N Explain: ______________________
11. Are there any other related/unrelated health conditions? Y N Explain: ______________________
12. Have you seen another health professional for this problem? Y N Explain: ______________________
13. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Y N Explain: ______________________
14. Women only: Are you currently pregnant? Yes___ No___ Uncertain___

REVIEW OF SYSTEMS/SOCIAL/FAMILY HISTORY

Craig A. Robin, D.C.

REVIEW OF SYSTEMS (COMPLETE). MARK ALL OF THE FOLLOWING CONDITIONS THAT YOU HAVE/HAVE HAD.

Constitutional	Musculoskeletal	Neurological	Cardiovascular	Respiratory
☐ Fever	☐ Back/Neck Pain	☐ Sudden Numbness	☐ High Blood Pressure	☐ Asthma
☐ Weight loss	☐ Headaches	☐ Sudden Headache	☐ Heart Disease	☐ COPD
☐ Obesity	☐ Extremity Pain	☐ Loss of Sensation	☐ Arterial Aneurysm	☐ Common Cold
☐ Loss of Appetite	☐ Bone Demineralization	☐ Confusion	☐ Angina	☐ Emphysema
☐ Fatigue	☐ Unstable Fracture	☐ Dizziness	☐ Irregular Heart Beat	☐ Pneumonia
☐ Anxiety	☐ Spinal Infection	☐ Slurred Speech	☐ Bleeding Disorder	☐ Cancer
☐ Allergies	☐ Spinal Bone Tumor	☐ Loss of Balance	☐ Heart Attack	☐ Pneumothorax
Eyes	**E, N, M, T**	**Genitourinary**	**Gastrointestinal**	**Disease History**
☐ Vision Trouble	☐ Hearing Loss	☐ Kidney Infection	☐ Diarrhea	☐ Stroke
☐ Double Vision	☐ Tinnitus	☐ Loss Bladder Control	☐ Blood in Stool	☐ Heart Attack
☐ Night Blindness	☐ Vertigo	☐ Urine Color Change	☐ Abdominal Pain	☐ Diabetes
☐ Glaucoma	☐ Nose Bleeds	☐ Painful Urination	☐ Liver/Gall Condition	☐ Cancer
☐ Cataracts	☐ Dry Mouth	☐ Urine Leakage	☐ Nausea/Heartburn	☐ HIV/AIDS
☐ Discharge	☐ Change in Taste	☐ Urgency	☐ Loss Bowel Control	
☐ Droopy Eyelids	☐ Bleeding Gums	☐ Blood in Urine	☐ Prostate Problems	

FAMILY AND SOCIAL HISTORY PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS.

Question					
How often do you exercise?	☐ Never	☐ 1x/week	☐ 2x/week	☐ 3x/week	☐ 4x/week
How often do you use tobacco?	☐ Never	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly
How many alcoholic beverages do you drink each week?	☐ 0	☐ 1-2	☐ 3-4	☐ 5-7	☐ >7
How many coffee beverages do you drink each week?	☐ 0	☐ 1-2	☐ 3-4	☐ 5-7	☐ >7
How many soda/sugar beverages do you drink each week?	☐ 0	☐ 1-2	☐ 3-4	☐ 5-7	☐ >7

List all prescription medications you are currently taking.

List all over-the-counter medications or nutritional supplements you are currently taking.

List all surgeries you have had.

List all times you have been hospitalized and why.

List all significant past traumas you have had (auto accidents, work accidents, falls, etc.). Did you break any bones? ☐ Yes ☐ No

Mark any/all of the following in your family history. ☐ Heart Disease ☐ Stroke/TIA ☐ Diabetes ☐ Cancer

Do you have a pacemaker? ☐ Yes ☐ No

"I certify that the information given is accurate and complete. I will not hold my doctor Craig A. Robin, D.C. or any members of his staff responsible for omissions or errors I have made in providing this information."

____
Print Patient Name

X______________________________
Patient/Guardian Signature

____
Date